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Abstract

Cesarean deliveries on maternal request (CDMR) have become increasingly common in China within the past 20 years, coinciding with the dramatic rise in cesarean section rates. In recent years, the state has tried to control the escalation of cesarean section rates by restricting those that are considered medically “unnecessary” and particularly those requested by mothers. Drawing upon eight weeks of ethnographic fieldwork and 34 interviews with women, providers and family members at a district hospital in Shanghai, this thesis looks at the sociocultural context that influences mothers in China to request cesarean deliveries, as well as the ongoing negotiations among the state, doctor and woman over control of the childbirth process. Examining the politics of delivery decision-making, in turn, provides a platform for understanding reproductive governance, childbirth and the underlying system of health care in China.

Disciplines

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Choice, Control and Childbirth:

Cesarean Deliveries on Maternal Request in Shanghai, China

By

Eileen Wang

A SENIOR HONORS THESIS

in

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Thesis Advisor: Dr. Adriana Petryna

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Abstract

Cesarean deliveries on maternal request (CDMR) have become increasingly common in China within the past 20 years, coinciding with the dramatic rise in cesarean section rates. In recent years, the state has tried to control the escalation of cesarean section rates by restricting those that are considered medically “unnecessary” and particularly those requested by mothers. Drawing upon eight weeks of ethnographic fieldwork and 34 interviews with women, providers and family members at a district hospital in Shanghai, this thesis looks at the sociocultural context that influences mothers in China to request cesarean deliveries, as well as the ongoing negotiations among the state, doctor and woman over control of the childbirth process. Examining the politics of delivery decision-making, in turn, provides a platform for understanding reproductive governance, childbirth and the underlying system of health care in China.

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Above all, I am thankful for my parents who have supported me throughout this process: for helping me find my way into and within China when I decided to take on this independent endeavor, for helping me translate difficult terms, and for providing moral and emotional support. I am deeply grateful for your love and care.

Introduction

"Cesarean! Cesarean! I want a cesarean!" A woman yells from the delivery room. She is lying flat on her back on the pink delivery bed, her legs awkwardly split open on the leg spreaders. Her hands grip the side rails of the bed, her hair mussed and her face beaded with sweat. Wrapped around her wrist is a plastic blue wristband listing her name: Daiyu¹; her age: 27 years old; and the number of children she has given birth to previously: 1. As she writhes in pain, I notice that no nurses come to her attention, although they are only a few feet away at the nurse's station. I approach Daiyu, paralyzed by my inability to do anything for her.

"I want a cesarean," she repeats.

"I don't know, I am not a doctor," I tell her, although I self-consciously note that I am wearing a white coat, the required attire for a student authorized to enter the labor and delivery room.

"Can you ask for me?" Daiyu pleads. "I want a cesarean! I want a cesarean! I want a cesarean!" Startled by her repeated cries, I go over to the nurses and tell them what they already know: that this woman wants a cesarean. Hua, one of the nurse-midwives, looks up at me from her papers, rolls her eyes, and then walks over to Daiyu.

"Why are you saying this now when you are having contractions? Your cervix has already dilated four centimeters. A cesarean is bad for you and the baby. If you don't have a medical reason for it, you can't get one. Your conditions are good for vaginal delivery," Hua tells her.

"I'm afraid! I don't want to give birth! I want a cesarean!" the woman continues to yell. In her pain, she starts pulling off the electronic fetal monitor probes strapped to her belly, which

¹All names in this thesis have been changed to protect individuals' identities.

track the baby's heartbeat. Hua, visibly upset, reacts, "It's not for you, it's for the baby!" and puts the probes back on. Eventually, four more nurses come in, each telling Daiyu that yelling is no use, that pain is not an excuse for a cesarean, and that every woman goes through childbirth like this. They then go back to their station. She continues to yell for a cesarean.

After some time, the delivery room becomes chaotic as the woman on the bed next to Daiyu's starts to deliver, and two nurses prepare for the final stage of birth. At the same time, Dr. Li, one of the head obstetricians at the hospital, arrives to see Daiyu. In response to Daiyu's repeated requests for surgery, she questions her, "Why are you asking now? Why not before, when your cervix hadn't opened yet?" She starts slapping Daiyu on her leg, before turning to me and saying, "Have you ever seen a woman make such a commotion?"

Moments later, Daiyu's cervix dilates completely to ten centimeters. Her baby proceeds down so rapidly that Hua scrambles to get the table prepared with sterile cloths. She puts on gloves, wipes Daiyu's bottom with a brown liquid disinfectant, and prepares the tools to stitch her vaginal opening in case it rips. Daiyu starts pushing, and the baby's head, hair matted with blood and mucous liquid, emerges into the bright fluorescent light. Hua pulls the baby out and cuts its umbilical cord. She holds the baby up to Daiyu: a boy. Daiyu lifts her head and nods in acknowledgement before resting her head back onto the bed. The nurse swaddles the baby in a thick blanket and places him under the incubator as Daiyu sinks into the delivery bed, recovering from the exhausting labor.

Daiyu was one of the many women and soon-to-be mothers I encountered during my fieldwork at Jiangbei Central Hospital² in Shanghai, China, and she was one of a significant

² The hospital and district name has been anonymized in this thesis.

number I saw and interviewed who had requested a cesarean delivery (C-section or CD).

According to many reports, rates of cesarean deliveries—a surgical procedure used to deliver a baby through the mother’s abdomen—have risen dramatically in China within the past 25 years, from 3.4% in 1988 to estimates of 58% in 2010, the highest rate in the world today.³ The reasons for this dramatic increase are multifold and may be, in part, due to China’s rapid development and urbanization increasing women’s access to hospitals.⁴ In China, the number of hospital births doubled from 45% in 1988 to over 90% in 2008, and almost 100% in high socioeconomic, urban areas like Shanghai.⁵ This has allowed more people to attain clinical care and C-sections, which can protect the mother or baby from injury or death when medically indicated.⁶ However, that more than half of Chinese women now deliver by surgery might be cause for alarm, as the World Health Organization (WHO) notes that any cesarean section rate above 10-15% in a population has no effect on reducing maternal and neonatal mortality rates, and may actually increase rates of maternal and neonatal morbidity compared to spontaneous vaginal delivery.⁷

Women’s requests for cesareans

One explanation for these high cesarean section rates are nonmedical, demand-side factors—particularly women’s requests to have a cesarean delivery for a low-risk pregnancy without a medical indication, termed as “cesarean deliveries on maternal request” (CDMR).⁸ In China, studies estimate that the proportion of cesareans requested by mothers has risen from 2%

³ Hellerstein, Feldman, and Duan, “China’s 50% Caesarean Delivery Rate”; Feng et al., “Factors Influencing Rising Caesarean Section Rates in China between 1988 and 2008.”

⁴ Feng et al., “Factors Influencing Rising Caesarean Section Rates in China between 1988 and 2008.”

⁵ Feng et al., “Socioeconomic Inequalities in Hospital Births in China between 1988 and 2008.”

⁶ National Institutes of Health, “Cesarean Childbirth.”

⁷ World Health Organization and Human Reproduction Programme, “WHO Statement on Caesarean Section Rates”; Lumbiganon et al., “Method of Delivery and Pregnancy Outcomes in Asia.”

⁸ Zhang and Liu, “National conference on cesarean delivery notes.”

of all cesareans in 1994 to 28% in 2011.⁹ Studies have found that, in general, women who have a higher level of educational attainment—who are also more likely to be covered by health insurance and have babies at relatively late ages—are more likely to request cesareans.¹⁰ They have also found that factors for their decision to have a cesarean include anxiety about the inability to complete a vaginal delivery—as we saw in Daiyu’s case—worry about fetal safety, concern about the effect of vaginal delivery on their figure or sex life, and the ability to choose an auspicious delivery date.¹¹

Another major reason that women request cesareans is the fear of pain.¹² This is particularly important as, in China, less than 1% of women in labor are given epidural analgesia, or pain medication injected into the spine during labor, common in childbirth in high-income countries.¹³ While epidural analgesia is known to be highly effective in controlling labor pain, the procedure has not been widely available in China. Although not much research has been done on the reasons why, many researchers speculate that staff and equipment costs, distrust of the procedure, and other misconceptions may restrict epidural adoption.¹⁴ In any case, women have come to believe that the only two ways to deliver are either “naturally” or by cesarean. In fact, the most commonly used term to refer to vaginal delivery is “*zi ran chan*” or “natural delivery,” which, in the English language, presumes the absence of medication or intervention. Therefore, many women, seeing no option for effective pain relief during labor, may opt for a cesarean section.

⁹ Zhang et al., “Cesarean Delivery on Maternal Request in Southeast China”; Liu et al., “A Descriptive Analysis of the Indications for Caesarean Section in Mainland China.”

¹⁰ Tang, Li, and Wu, “Rising Cesarean Delivery Rate in Primiparous Women in Urban China.”

¹¹ Ibid.

¹² Lee, Holroyd, and Ng, “Exploring Factors Influencing Chinese Women’s Decision to Have Elective Caesarean Surgery”; Li and Zhao, “Changes in Indications of Cesarean Section and Its Influencing Factors.”

¹³ Fan, Gao, and Yang, “Popularizing Labor Analgesia in China”; Hu et al., “Impact of the Introduction of Neuraxial Labor Analgesia on Mode of Delivery at an Urban Maternity Hospital in China.”

¹⁴ Ibid.

Still, while cesarean sections can be life-saving operations for a mother and her baby, there is increasing concern about the rise in these unnecessary cesarean deliveries. As C-sections are major surgical procedures, in cases where they are non-medically indicated, studies show that maternal morbidity and mortality increases compared to cases of women delivering vaginally. In a World Health Organization (WHO) global survey on maternal and neonatal outcomes in Asia, Lumbiganon et al. (2010) found that compared to spontaneous vaginal delivery, cesarean delivery without medical indication was associated with increased risk of maternal mortality, admission to the intensive care unit, blood transfusion, or hysterectomy.¹⁵ Furthermore, a cesarean for women who have never previously had children increases the risk of uterine rupture, spontaneous miscarriage, abnormal placentation, and other complications in subsequent pregnancies.¹⁶

Physician incentives for performing cesareans

Researchers have also looked at why physicians would so easily acquiesce to performing medically unnecessary cesareans. One critical aspect is the structure of the Chinese obstetric care system and provider financial incentives. Almost all women in Shanghai give birth at primary, secondary or tertiary hospitals, which are tiers of hospitals that progress from providing basic to more specialist health services.¹⁷ A majority of those give birth at one of China's government-owned and managed hospitals, which account for 94% of total discharges and 92% of outpatient visits.¹⁸ The system of health care financing at public hospitals, however, distorts physician incentives to perform more cesarean sections. These public hospitals receive around 25% of their

¹⁵ Lumbiganon et al., "Method of Delivery and Pregnancy Outcomes in Asia."

¹⁶ D'Souza and Arulkumaran, "To 'C' or Not to 'C'?"

¹⁷ Feng et al., "Socioeconomic Inequalities in Hospital Births in China between 1988 and 2008."

¹⁸ Eggleston, "Health Care for 1.3 Billion."

revenue from the government to pay their personnel, the rest of which must be generated from user fees. At the same time, the government imposes a system of price regulation that controls the amount that hospitals can charge for routine visits and services, but not new drugs and technology. As a result, in order for hospitals to make a profit and to pay its physicians, they must generate money through costly procedures. The higher the number of procedures like cesarean sections, the higher the staff's income through bonus payments.¹⁹ In addition, due to the increased access to care and the centralization of medical care at the hospital, the overall volume of deliveries in Chinese hospitals is high. At the same time, staffing levels are low and limited by hospital budgetary constraints—there are only 1.46 doctors and 1.51 nurses or midwives per 1000 people in China, compared to 2.42 and 9.82 per 1000 people, respectively, in the US.²⁰ The strain of the patient workload pressures physicians to be efficient in their work, favoring a high cesarean rate. The concentration of women in hospitals in an overstrained medical system may also, in part, explain why cesarean section rates are much higher in urban areas than rural areas and in tertiary hospitals than secondary or primary ones.²¹

Changes in China's cesarean section policy

The skyrocketing C-section rate in China was a cause for alarm, particularly after the publication of the 2010 WHO study demonstrating the public health hazards of unnecessary C-sections.²² Since then, the National Health and Family Planning Commission of the People's

¹⁹ Hsiao, "The Chinese Health Care System"; Blumenthal and Hsiao, "Privatization and Its Discontents — The Evolving Chinese Health Care System"; Feng et al., "Factors Influencing Rising Cesarean Section Rates in China between 1988 and 2008"; Bogg et al., "Dramatic Increase of Cesarean Deliveries in the Midst of Health Reforms in Rural China."

²⁰ Hellerstein, Feldman, and Duan, "China's 50% Cesarean Delivery Rate," 162; Liu et al., "The Relationship between Hospital Work Environment and Nurse Outcomes in Guangdong, China."

²¹ Sufang et al., "Delivery Settings and Cesarean Section Rates in China"; Tang, Li, and Wu, "Rising Cesarean Delivery Rate in Primiparous Women in Urban China."

²² Dr. Xiaohua Liu. Informal Interview by Eileen Wang. Shanghai, China. June 16th, 2015.

Republic of China (NHFPC), an executive agency under the State Council that monitors and ensures the quality and accessibility of health services and family planning, has renewed efforts to lower the country's rates of cesarean deliveries. In 2011, the Chinese State Council issued a document on the "Development of Chinese Women (2011-2020)," a plan to protect women's rights and promote their welfare in education, health, law, etc.²³ Under this declaration, the state aims to improve the quality of obstetric services and maternal health care through a number of initiatives, one of which is to "provide the necessary psychological guidance and health education to pregnant women, disseminate knowledge about natural childbirth based in scientific knowledge, and control the cesarean section rate."²⁴ In line with this policy, the NHFPC has refocused efforts on implementing the WHO and the United Nations Children's Fund (UNICEF)-guided "Baby-Friendly Hospital Initiative." The initiative monitors and grades hospitals on standards for supporting "optimal infant and young child feeding" including universal breastfeeding.²⁵ However, in China, the initiative also includes provisions on "promoting natural childbirth" and "gradually reducing non-medical indications for cesarean section rates year by year." As such, hospitals are given higher grades, and therefore more money, if they have implemented initiatives to reduce medically "unnecessary" cesarean sections—a financial incentive that affects physicians paid by hospital revenues.²⁶

My ethnographic research, which involved two months of fieldwork in Shanghai, looked at this particular phenomenon of CDMR in China, and especially in light of this new policy. I conducted my fieldwork in Shanghai, China, at Jiangbei Central Hospital, the main medical and

²³ "Development of Chinese Women and Children's Development Programme in China."

²⁴ Ibid.

²⁵ World Health Organization and UNICEF, "BFHI Section 1: Background and Implementation."

²⁶ "National Health and Family Planning Commission Notice on the review of the Baby Friendly Hospital Initiative."

prevention center of Jiangbei District and representative of a typical public, urban hospital where Chinese women give birth. Throughout my research, the central questions I asked were: what are the sociocultural factors that influence mothers in China to request to deliver by cesarean? To what extent are those requests acknowledged or rejected by doctors, and how do larger structural factors, like state policy, play into these doctor-patient interactions?

Using anthropological sources, as well as observations and interviews with women, providers, and family members at Jiangbei, I argue that cesarean deliveries on maternal request in China is a complex sociocultural phenomenon, involving negotiations among the state, doctor, and woman over control of the childbirth process and notions of health, risk and pain. Even within the context of state intervention, women continue to exercise their own agencies in the childbirth process, revealing the intricacies of power dynamics in on-the-ground birth decisions. Moreover, this thesis explores the politics of cesarean deliveries as a platform for understanding childbirth and the underlying system of health care and maternal services in China.

In the **first chapter**, I will outline a brief history of state intervention in reproduction and childbirth in China and show how cesarean decision-making has come to fall under the purview of the state. I argue that policies that medicalize birth, control population quantity, and govern cesarean sections construct the woman's body as a site of societal control for the state's purpose of improving "population quality" and modernizing through science and biomedicine. However, these policies have particular consequences for women's experience of and decision-making in birth.

In the **second chapter**, I will describe how scientific rationality governing childbirth translates into women's experiences of birth and interactions among health care providers, women, and their families at Jiangbei Central Hospital. I will show how childbirth, in line with

the state's goals, has come to be controlled by biomedical authority and its technology. At the same time, the medical model of birth creates a predominant narrative of childbirth as a risky process that must be managed by medical professionals. Within this model, women and physicians come to view cesarean sections as a technological solution to control that risk.

In the **third chapter**, I will explore the politics of pain and pain relief surrounding childbirth. I argue that the context in which women give birth constructs their experience and expression of childbirth pain, as well as the negotiation of its relief. In particular, the lack of emotional support, cultural norms surrounding the expression of the labor pain, and lack of access to pain medication for vaginal delivery drive many women to request cesarean deliveries before or during labor. In both cases, women try to use cesareans to negotiate their way around the experience of labor pain within the restricted arena of pain relief and social norms.

In the **fourth chapter**, I will focus on the interaction of all of the actors: state, provider, and woman, at the point of decision-making. In light of the recent state regulations circumscribing CDMR, women nevertheless continue to successfully request cesareans and navigate state and medical authority over delivery decision-making. Those who do so must have a certain knowledge base, social or economic capital, or proof of some valid risk calculation to convince the doctor to deviate from her "scientific judgment." On the other hand, those who do not possess that capital, namely poorer migrant workers, continue to be subject to medical and state authority.

In my conclusion, I will reflect on the implications of my ethnographic research, particularly for improving women's experiences of childbirth. I will conclude by discussing other questions that my research findings raise about childbirth and health care in China and elsewhere.

Ethnographic Orientation

I chose Shanghai, China for this ethnographic study for two reasons. First, Shanghai is a large city and, based on the literature, rates of CDMR in China are the highest in urban areas.²⁷ Second, I was able to obtain access to the obstetric-care system in Shanghai through my mother's friend, who connected me to one of the head obstetrician-gynecologists (OB/GYN) at Jiangbei Central Hospital. Through my physician-contact, I was able to conduct fieldwork there from June 5th to August 4th, 2015. I observed the OB/GYN department, shadowed physicians in the inpatient and outpatient divisions, and accessed the labor and delivery ward; the common patient wards for antepartum and postpartum women; and the "VIP" patient wards for women who booked private hospital rooms. Every day, I recorded my notes in a small notebook and then typed them into my laptop.

During my fieldwork, I quickly learned new medical vocabulary relevant to the field of OB/GYN; collected and took pictures of the various forms, brochures, and posters related to pregnancy and childbirth handed out or displayed to women; and attended prenatal classes offered by the hospital. As the weeks progressed, I spent more time in the labor and delivery room and patient wards so that I could interview antepartum and postpartum women and, if possible, see them during labor and after birth. I used convenience sampling to recruit interviewees, often simply entering a patient room, introducing myself and what I was doing at Jiangbei, and asking for their consent to interview them. Other times, I observed women in the labor and delivery room, and after they were released to the patient wards, sought them out for interviews.

²⁷ Klemetti et al., "Caesarean Section Delivery among Primiparous Women in Rural China"; Long et al., "High Caesarean Section Rate in Rural China."

I interviewed and tape-recorded a total of 26 postpartum women, 12 of whom delivered vaginally and 14 of whom delivered by cesarean. Of those, I followed four of them from antepartum to postpartum. Because there were typically no private rooms in the hospital available for closed-door interviews, I interviewed women while they were recovering in the patient wards, typically with their newborn, husband, and/or mother-in-law present, whom I sometimes informally interviewed, as well.²⁸ The interviews were in-depth and semi-structured, although they proceeded like free-flowing conversations. In general, I asked the interviewee about her birth experience (or expectations of birth for antepartum women), her education on and preparation for birth, her relationship with the doctor, and her opinions on vaginal versus cesarean delivery. I also interviewed four labor and delivery nurse-midwives, two outpatient nurses, and two OB physicians, most of whom I came to know well over the course of my fieldwork. I inquired about their everyday roles, educational and training experiences, reactions to women who request cesareans, beliefs as to why women request cesareans, own birth experience (if applicable), and perceived professional pressures.

Since I was conducting research with human subjects on a potentially sensitive topic, I first underwent a CITI training course in human subjects research and received the University of Pennsylvania's Institutional Review Board approval to conduct this research. Prior to each semi-structured interview, I detailed the purpose of my study and obtained participants' consent to be interviewed and recorded. I told them that they did not have to be interviewed, nor did they have to answer every question if they did not wish to do so. All information was kept confidential on my password-secure laptop. In addition, I have anonymized the names of the district, hospital, and interviewees to protect the confidentiality of the research participants.

²⁸ In general in China, it is usually the mother-in-law attends to the woman in the hospital during childbirth, although occasionally the mother may be present.

After returning from China, I transferred all of the interview recordings to my password-secured laptop and then translated and transcribed them using the transcription software Express Scribe. Through listening to the interviews and re-reading the transcripts, I abstracted some larger themes that created a narrative of childbirth and the maternal health services system in China. These were complemented by my fieldnotes (including notes from informal interviews and observations), documents, and both English and Chinese secondary literature in anthropology, history, and public health.

Positionality

As a first-generation Chinese-American, I was both an outsider and an insider to Chinese culture. This dual identity aided me in navigating my fieldwork and interviews. First, I was able to speak and understand Mandarin, the main language spoken at the hospital, and did not require a translator. I introduced myself to mothers and providers as an American student doing research for my thesis in China. Since I was seen as an outsider, they took a matter-of-fact, common-sense approach of explaining their understanding and experience of childbirth to me. Conversely, they would also ask about childbirth in the US, building rapport and creating a mutual dialogue. In addition, because I was a young female of child-bearing age, I felt that women were more likely to trust me and open up about their childbirth experience.

Still, in order to be authorized to access patient wards and the labor and delivery room, I had to wear a white coat and an ID badge. The white coat, symbolic of the medical profession, no doubt created an invisible barrier between me and women, or at the very least created the perception that I possessed some sort of medical authority. Before interviewing women, therefore, I would emphasize that I was an American undergraduate student doing a research

project, and not a doctor affiliated with the hospital. I believe that my slight accent and clumsiness with Mandarin aided this perception and relaxed any perceived power dynamic. I admit, however, that this was not always foolproof. Sometimes in the delivery room, women (such as Daiyu) would think I was a nurse-midwife or medical student, and would ask me for help. Other times, when I asked women what they thought of vaginal or cesarean delivery methods, they would turn back the question on me, presuming I knew more than they did. Perhaps they thought there was a “right” or “wrong” answer, or that I was associated with medical authority. Still, I tried as much as I could to disabuse them of that idea. Unlike the medical professionals, I often spent an hour or two with each woman in her room, which lent to the idea that I was not someone there to treat, direct or govern her. I was merely there to listen and to learn.

Brief background on the district and hospital

I conducted my ethnographic fieldwork in Jiangbei, a suburban district of Shanghai. This district has around 540,000 permanently registered residents; however, the actual population is around 1.4 million, indicating the large presence of temporary residents residing in the district for work. The district is well-developed and is an important industrial base, largely focused on auto parts manufacturing, electronics, and information technology. In addition, it houses many science and technology research institutions and the satellite campuses of a number of Shanghai universities.

Jiangbei Central Hospital is the main hospital of the district and is classified by the Shanghai Municipal Bureau of Health as a secondary-level hospital. It is a public, state-owned hospital, and provider salaries come from the government, although bonuses are paid by the

hospital through its revenues from user fees. It holds around 700 beds and is comprised of 17 clinical departments. Approximately 2400 women give birth there every year, about 800 of which are cesarean deliveries (around 33%).

Jiangbei is representative of a large, urban hospital in which Chinese women give birth and, as the literature note, tends to have high rates of CDMR—the phenomenon I intended to investigate. However, the majority of women at Jiangbei were not Shanghai residents, but rather, temporary workers from other, more rural provinces. The majority of women I interviewed often had only a junior high or high school education and possessed government-provided insurance (called the New Cooperative Medical Scheme, for rural residents), which did not apply outside their home province. This affected the nature and scope of my original research question to explore CDMR, which is described in the literature to be more common among urban, educated women. Still, what I found is that the current notion of what constitutes a “request” for a cesarean in the public health literature is problematic. Defining and quantifying rates of CDMR may obscure the experiences of women, particularly those of lower socioeconomic status, who may not have “requested” cesareans according to the official definition (singleton birth, cesarean delivery on “woman’s request,” viable fetus, gestational age of 38 weeks or more, and before the onset of labor²⁹) but nevertheless have asked for the cesarean during labor or possess the same underlying fears and socialization to medical technology in childbirth as those who did. Therefore, as part of this anthropological work, I hope to elaborate upon these class dynamics and construct more nuanced notions of what constitutes a “maternal request” for a cesarean.

²⁹ Zhang et al., “Cesarean Delivery on Maternal Request in Southeast China.”

I

State Authority over Birth

Childbirth in China has been shaped by a long history of reproductive governance, or state intervention in controlling reproductive practices to manage and improve the population.³⁰ Although regulation over reproductive practices began as early as the Nationalist era of the 1920s after the Republic of China was founded, I focus on reproductive governance after 1949 when the communist regime came into power, establishing the People's Republic of China.³¹ As anthropologist Susan Greenhalgh argues, during this time, the regime became concerned about limiting the quantity and raising the “quality” of the population in order to modernize its citizens, strengthen the regime, and transform China into a major power within the globalized economy.³² According to Greenhalgh, this emphasis on population quality has given rise to new objects of societal investment and control: the “good mother” who disciplines her body and embraces scientific mothering practices, and the “quality child” which the mother produces.³³ As reproducers of the quality child, responsible for the nation's future, women and their bodies become a site of struggle over power.³⁴

As I argue in this chapter, the state has used programs promoting biomedical practices in childbirth, implementing family planning practices, and controlling cesarean delivery rates to improve population quality, build upon their modernizing agenda and justify control over childbirth. At the same time, these practices that view women as objects of population policy

³⁰ Morgan and Roberts, “Reproductive Governance in Latin America,” 242; Foucault, *The History of Sexuality*, 1:146.

³¹ Johnson, *Childbirth in Republican China*; Harvey and Buckley, “Childbirth in China.”

³² Greenhalgh and Winckler, *Governing China's Population*, 30.

³³ *Ibid.*, 236.

³⁴ *Ibid.*, 30.

have created in women an experience of pregnancy and childbirth that relinquishes their body to state and medical authority.

The promise of biomedicine: From the home to the hospital

Like many of the woman I met in the patient wards, Chenguang, a 31-year-old and second-time mother, talked to me while lying in her hospital bed. She was mentally alert, but relatively immobile after the cesarean delivery of her second child. Chenguang told me that she originally wanted to have a vaginal delivery for this pregnancy, but because her first child had also been delivered by cesarean back in her home province of Anhui, the doctor warned her uterus could potentially rupture at the site of the cesarean scar if she attempted vaginal delivery. She went ahead with the physician-recommended cesarean. However, during the surgery, after her baby was taken out, her placenta remained stuck to the wall of her scarred uterus. She started hemorrhaging. The doctors reacted quickly and were able to staunch the blood loss, and Chenguang was able to fully recover.

By contrast, Juan, Chenguang's mother-in-law, had a very different birth experience in rural Anhui. She told me that, during the 1980s, she gave birth at home with a *jieshengpo*, or a traditional midwife. During that time, there were very few hospitals in her area, and those that were in existence were of poor quality. Surgical delivery was not a viable option for her. When I asked Juan whether she believed that giving birth in the hospital was better than doing so at home, she immediately told me she preferred hospitals:

“A lot of women who delivered with *jieshengpo* would die from hemorrhage and such. No one could treat them. Now that it's in hospitals, if you have a hemorrhage, they will treat it immediately. For example, when my aunt gave birth [at home], her child survived, but she died. They couldn't do anything about it.”³⁵

³⁵ Juan Wang. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 8th, 2015.

Chenguang also said she preferred to have a child in the hospital, “Because the hospital has specialists. If you were giving birth at home, you would only have *jieshengpo*—they don't have the equipment or technology. And the risks are higher at home.”³⁶ Indeed, Chenguang survived her hemorrhage precisely because she had obstetricians and anesthesiologists who could promptly treat it with medical technologies. Perhaps she would not have survived if she had been in Juan’s position, giving birth at home with a *jieshengpo*.

Juan and Chenguang’s contrasting childbirth experiences at home with *jieshengpo* versus in the hospital with biomedical doctors speak to China’s broader historical campaign to use science to modernize the state. Throughout the twentieth century, the state believed “science” to be the prime source of truth, a solution to China’s problems, and a path towards modernity, wealth and power.³⁷ In particular, the Cultural Revolution in the mid-1950s, a socio-political movement in China spearheaded by Mao Zedong to purge the country of capitalist influences, had slowed the economy and left an entire generation with no formal education. The persecution, human rights abuses and turmoil that the Cultural Revolution produced left China desperate for political, economic and social stability.³⁸ After Mao’s passing, the state saw science as the antidote to the horrors of the Cultural Revolution and the nation’s weaknesses, naming it the first of China’s “four modernizations” (along with agriculture, industry and national defense).³⁹ One key goal, for example, was to use science to discipline the maternal body and improve the health

³⁶ Chenguang Wang. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 8th, 2015.

³⁷ Greenhalgh, “Science, Modernity, and the Making of China’s One-Child Policy,” 171.

³⁸ For more, read Richard Curt Kraus, *The Cultural Revolution: A Very Short Introduction*, or Roderick MacFarquhar and Michael Schoenhals, *Mao’s Last Revolution*.

³⁹ Harvey and Buckley, “Childbirth in China,” 57. Greenhalgh, “Science, Modernity, and the Making of China’s One-Child Policy,” 171.

of women in reproduction and childbirth, thus ensuring the “quality child” and future economic viability and stability of China.⁴⁰

To this end, China has taken concerted efforts to cast aside “backward” practices, such as home births and midwifery, which were seen as the cause of mother and infant deaths due to midwives’ inadequate and unsanitary techniques.⁴¹ In 2000, the provincial Health Bureaus abolished all traditional birth attendants’ licenses and defined home birth as “illegal,” citing poor quality of care and the hospital as a site for safer births.⁴² Those *jieshengpo* still practicing would be fined up to 20,000 yuan (around 2400 US dollars at the 2000 exchange rate).⁴³ Moreover, one could only get a birth certificate or household registration, the documents the child needs to be identified as a member of the state, if one gives birth at the hospital—further discouraging home births.⁴⁴

At the same time, the Chinese drew upon Western scientific practices and the US obstetric model to manage childbirth within the hospital.⁴⁵ Obstetricians and *zhuchanshi* (“nurse-midwives”), trained in the biomedical interpretation of birth, came to replace midwives as attendants at birth and rose to a powerful position in governing childbirth. Chinese media regarded the phasing out of midwifery and “un-scientific” practices and the emergence of hospital-based childbirth as a big step forward for Chinese society.⁴⁶ The medical profession thus emerged as a major player in shaping birth decisions and experience.

⁴⁰ Greenhalgh and Winckler, *Governing China’s Population*, 234.

⁴¹ Johnson, *Childbirth in Republican China*, xxv–xxvi.

⁴² Huang, “Illegal home birth in rural areas and the countermeasures.”

⁴³ “Currency Converter.”

⁴⁴ Wang, “Regulate the issue of birth certificate, promote designated hospital birth, improve hospital birth rate.”

⁴⁵ Cheung, Mander, and Cheng, “The ‘Doula-Midwives’ in Shanghai.”

⁴⁶ “Tianjin Leads China’s Rural Areas in Bidding Farewell to Midwives”; “Midwifery Phased out in China’s Rural Areas.”

As a result of these efforts, the number of hospital births in China doubled from 45% in 1988 to over 90% in 2008.⁴⁷ This has decreased maternal mortality ratios and neonatal mortality rates, due to the availability of medical procedures for emergency situations endangering the mother or child.⁴⁸ One study estimated that between 1996 and 2008, 48-70% of neonatal deaths were prevented by moving births to the hospital.⁴⁹ Still, even as China has been successful in controlling maternal and neonatal mortality by funneling births through its hospitals, this transformation has also shaped the woman's pregnant body as a site of regulation and control by state and medical authority.⁵⁰ As I will show in the next chapter, this medicalization of birth creates particular power dynamics over the birthing body in the name of health and the "quality" child.

Controlling population quantity: The one-child policy

Post-Mao, the state believed that the burgeoning population was a major cause of China's poverty and hindered progress toward the four modernizations, particularly if the population was of "poor quality."⁵¹ Anthropologist Ann Anagnost notes that the state viewed its population as an "overlarge, ignorant, and backward mass," and as a consuming body that outweighed its productivity. In order strengthen China's power in larger society, it had to limit quantity while raising quality of bodies, disciplining them for the workforce within China's emerging economy.⁵² As such, in 1979, China implemented the Planned Birth Policy (otherwise known as

⁴⁷ Feng et al., "Socioeconomic Inequalities in Hospital Births in China between 1988 and 2008."

⁴⁸ Ibid.; Yanqiu, Ronsmans, and Lin, "Time Trends and Regional Differences in Maternal Mortality in China from 2000 to 2005."

⁴⁹ Feng et al., "China's Facility-Based Birth Strategy and Neonatal Mortality."

⁵⁰ Greenhalgh and Winckler, *Governing China's Population*, 240.

⁵¹ Greenhalgh, "Planned Births, Unplanned Persons"; Greenhalgh and Winckler, *Governing China's Population*, 2.

⁵² Anagnost, "A Surfeit of Bodies: Population and the Rationality of the State in Post-Mao China," 30.

the “one-child policy”), a policy that limited the number of children a woman could have by charging penalties for having extra children, and in the 1980s and 1990s, by using coercive techniques such as late-term abortions and forced sterilizations.⁵³ The one-child policy was the state’s manifestation of what Foucault called *biopower*: discipline and surveillance of the individual woman’s body for the sake of achieving progress and modernity for its social and political bodies.⁵⁴

This larger regime of reproduction, in turn, produced unintended consequences in how individual women perceived and experienced pregnancy and birth. Because families could only have one child, it raised the value of their only child. Parents wanted a “perfect” baby, as they only had one opportunity to do so. Both parents and providers did not want to risk vaginal delivery, believing that their child would be safer with a cesarean delivery (and still do, as I will elaborate upon in the following chapter). Several of the doctors and nurses told me that the notion of a “precious child” was significant factor to why a woman would request a cesarean, thus suggesting that the increased cesarean delivery rate was, at least in part, due to the social consequences of the family planning policy.⁵⁵ Xiulan, a 35-year-old nurse-midwife at Jiangbei, requested a cesarean in 1999 because she feared for the baby’s safety during labor. She told me,

During that time, I was thinking I was only going to have one child, and I was pretty short, so I didn’t want to *zheteng* [squander time]. I just feared that something would happen to the baby, because I was only having one child. And if something happens to the child, what then?”⁵⁶

In addition, although Xiulan knew a cesarean delivery increased the health risks for subsequent pregnancies, she did not even factor this into her risk-benefit analysis—after all, she

⁵³ White, *China’s Longest Campaign*, 147, 221; Anagnost, “A Surfeit of Bodies: Population and the Rationality of the State in Post-Mao China”; Chen, “Globalizing, Reproducing and Civilizing Rural Subjects: Population Control Policy and Constructions of Rural Identity in China.”

⁵⁴ Foucault, *The History of Sexuality*; Greenhalgh and Winckler, *Governing China’s Population*, 286.

⁵⁵ Dr. Jing Li. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 7th, 2015.

⁵⁶ Xiulan Zhao (nurse-midwife). Interview by Eileen Wang. Tape Recording. Shanghai, China. July 15th, 2015.

was only going to have one child. Because of this, and the fact that she could avoid the pain and risks of labor, she chose to have a cesarean delivery.

In 2013, more than 14 years after Xiulan gave birth, the state relaxed the family planning policy, passing a document that allows families to have two children if both the husband and wife are single children. In 2015, the Chinese government further expanded the policy to allow two children for any couple, with the intent to “balance population development and address the challenge of an aging population.”⁵⁷ These shifting socio-political circumstances have once again changed the context in which families make decisions in childbirth. On one hand, women with cesarean section scars are coming back to have second children. As many physicians in China are unwilling to attend a vaginal birth after cesarean (VBAC) due to the risk, albeit low, of uterine rupture, the number of those with repeat cesarean section increases.⁵⁸ On the other hand, those coming in pregnant with their first child have become aware that if they chose to have a cesarean, they would have to get repeat cesareans for subsequent children. As such, more and more women are now choosing to deliver their first child vaginally.⁵⁹ For women like Xiulan, however, the past cannot be undone. She told me, “These few years that they have relaxed the one-child policy, I have been upset. If I knew earlier, I would have tried delivering vaginally myself.”⁶⁰ Very specific circumstances had shaped her choice to have a cesarean delivery six years earlier. Now that these have shifted, however, Xiulan cannot change her previous decision, nor can she have more children, particularly as the risk of another surgical delivery would be too great.

⁵⁷ For more information, see “China to Allow Two Children for All Couples.” *Xinhua*. October 29, 2015. http://news.xinhuanet.com/english/2015-10/29/c_134763645.htm.

⁵⁸ Cunningham et al., *Williams Obstetrics 24/E*. Cunningham et al., *Williams Obstetrics 24/E*. Dr. Jing Li. Informal interview by Eileen Wang. Shanghai, China. June 10th, 2015.

⁵⁹ Dr. Ye Zhang. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 6th, 2015.; Fang Liu (nurse in the outpatient department). Interview by Eileen Wang. Tape Recording. July 7th, 2015.

⁶⁰ Xiulan Zhao (nurse-midwife). Interview by Eileen Wang. Tape Recording. Shanghai, China. July 15th, 2015.

The implementation of the one-child policy was a calculated measure by the state to modernize Chinese society. However, this has also molded how individual women react to state intervention in childbirth, particularly in increasing demand for cesareans. In the next section, I will explain how the Chinese government has responded to these reactions with further restrictions governing reproductive decisions.

Controlling population quality: reducing cesarean delivery rates

According to Greenhalgh, notions of population quality in China are predicated upon the use of “scientific knowledge” of reproduction and quantitative understandings of the population problem.⁶¹ Given the scientific evidence that demonstrates that unnecessary cesareans are linked to higher rates of maternal morbidity, the Chinese government views them as a threat to population quality and has therefore tried to manage it. In its 2011 issuance of its national program on the “Development of Chinese Women (2011-2020),” the State Council declared that, aside from ensuring the national hospital delivery rate is above 98%, one of their goals is to “provide maternal health education and psychological guidance, disseminate knowledge about natural childbirth, *help choose the most scientific mode of delivery*, and control the cesarean section rate” [emphasis added].⁶² Indeed, many of the brochures and pamphlets that the Shanghai government provides to women include appeals to the benefits of natural parturition, much of which focuses on scientific knowledge of its benefits to babies and mothers (See Appendices 1 and 2). During the pregnancy class offered to women at Jiangbei, the nurse-midwife director Nurse Wen exhorted the advantages of vaginal delivery over cesarean delivery:

⁶¹ Greenhalgh and Winckler, *Governing China's Population*, 289.

⁶² “Development of Chinese Women and Children’s Development Programme in China.”

how even if there is a tear in the vaginal opening, the cesarean cut is larger; how if the abdomen is cut, air will leak out, which would not be good for the baby; how vaginal deliveries harm the abdomen less; and how they can help babies breathe better and give them better immunity. She then explicitly told the women that while not all cesareans are bad, it is a scientific procedure that must be done with specific criteria. She told the women, “Chinese people always do things to extremes. They do not follow scientific procedures, which is why cesarean rates are above 50%. *This reduces population production quality*” [emphasis added].⁶³

The message that the state sends to women through public prenatal education assumes that women are not making rational decisions in childbirth, particularly as they are not based in “science.” According to the state, if cesarean sections are not being used appropriately in the most scientific *manner* for the appropriate circumstances, they lead to increased maternal and neonatal morbidity thus reducing the overall goal of population quality. Such ideas thus justify the state and medical profession’s regulation over individual delivery decisions. In order to create healthy babies, women had to relent their own judgment to the population and medical experts, accepting such internationally-backed, scientific ideas as authoritative.⁶⁴

In this chapter, I have shown that the state has been an active player in the childbirth experience through its reproductive policies in the name of population quality and modernity. In the subsequent chapters, I will take a ground-up perspective on childbirth in China, connecting how these broader state policies manifest in local circumstances. I will describe how “scientific” conceptions of childbirth and medicine have influenced how childbirth is managed; women’s views of their bodies and role at the time of labor and birth; and the landscape of excessive

⁶³ Xiuying Wen (nurse-midwife director). Observation of prenatal pregnancy class. Tape Recording. Shanghai, China. June 23rd, 2015.

⁶⁴ Greenhalgh and Winckler, *Governing China’s Population*, 240–241.

technological intervention. I will also argue how the state's regimes of reproduction invoking population quality, health and science are challenged in the individual negotiations over cesarean deliveries. In particular, while the state views cesarean sections as a way to manage the health of *populations*, doctors and women view them as a way to manage risk for individual circumstances, as well as personal experiences of pain and suffering.

II

The Medical Model of Birth

“Gao Chunhua. Gao Chunhua. Please proceed to the nurse’s desk,” the automated female voice broadcasts to the OB/GYN waiting area, which is filled with pregnant women and their families. For Chunhua, 23 years old and 38 weeks pregnant, this is her ninth prenatal visit to Jiangbei Central Hospital. The process of seeing the doctor has become routine. She approaches the station and hands her blue hospital card to the nurses at the desk. She pays for the appointment and waits again outside of the doctor’s office in the adjacent hallway. The queue for the doctor is at number 48. She is number 53, so she waits some more before the automated female voice once again calls her name to enter the doctor’s office.

As soon as she walks in, Chunhua gives the doctor her prenatal booklet which outlines instructions for her pregnancy and contains a table chart for each of the ten prenatal visits she is supposed to make to the hospital. Without even looking up at her, Dr. Zhang, the attending 30-year-old OB/GYN and graduate of the prestigious Zhejiang University School of Medicine, tells her to lie down on the bed. As Chunhua obeys, Dr. Zhang starts scribbling on her paper record before getting up to measure her belly with a measuring tape and listen to the baby’s heart rate using a fetal doppler machine. Before Chunhua even has time to wipe the fetal doppler gel off her stomach, Dr. Zhang is back at the desk, scribbling some more on the record. Dr. Zhang then shuttles Chunhua off to another part of the hospital to get an ultrasound and fetal stress test.

After Chunhua pays, gets the ultrasound and fetal stress test, and retrieves her test results, she returns to Dr. Zhang’s office. Three other women are already in the room, waiting for Dr. Zhang. She is nowhere to be found—apparently off pumping breastmilk for her own 10-month child. Finally, when Dr. Zhang returns, she speeds through the line of women with their test

results before turning to Chunhua. Dr. Zhang glances at Chunhua's results slip, says nothing, and then glues it upon the stack of other tests and notes in Chunhua's record. The sticker on her record indicating her risk-level remains green – she is low-risk. Other women who have high blood pressure, heart disease, or diabetes are given higher ratings, and their records are marked with yellow, orange or red stickers. Not once, during the five minutes Chunhua spends with Dr. Zhang does she inform her about the process of childbirth—that is communicated in the pregnancy classes offered at the hospital every Tuesday and Friday, although Chunhua decides not attend.

Chunhua comes back to the hospital a week later, because she is experiencing regular labor pains, signaling the start of childbirth. This time she is admitted to the in-patient department and is assigned a bed number in the third-floor OB/GYN patient ward. The ward, consisting of rooms spaced along a hallway and a central nurse's station, is busy. Beds overflow into the hallways as there is no more space in the rooms. Chunhua shares a room with two other women, one of her whom is hooked up to drip bag with pain analgesia, recovering from a recent cesarean delivery. The other woman lies on the bed breastfeeding her baby as her mother-in-law prepares porridge for her. Nurses in starched white uniforms and rectangular caps cycle in and out of the rooms, adjusting medication, getting women to sign forms, or performing postpartum examinations.

Once Chunhua's cervix is past three centimeters dilated, she is moved to the labor ward, which is across the hospital on the same floor. The ward consists of six beds side-by-side in an open room. Doctors or nurse-midwives, dressed in scrubs, a surgical hair net and mouth mask, examine her cervix with their gloved fingers every few hours to monitor her progress. They then strap an electronic fetal monitor, which tracks the fetal heart beat and transmits the signal to a

machine, to her belly. Once Chunhua's cervix is about seven or eight centimeters dilated, she is wheeled in a wheelchair to the delivery room. A nurse helps her onto a pink obstetric bed-table, places her legs on foot spreaders, and tells her to grab the handlebars to help her push. As the baby's head descends, the nurse-midwives open a sterile blue package and wear protective gowns and gloves. They cover her leg area, leaving a rectangular opening for the baby to come out, shave her pubic hair and wipe her vaginal area with iodine. When the baby's head is about to emerge, the nurse-midwife delivering the baby performs an episiotomy, a surgical incision of the tissue between the vaginal opening and the anus to widen the opening for the passage of the baby's head. As soon as the baby is delivered, the midwives work together to cut the cord; wrap the baby and weigh it; examine the placenta to make sure it is completely intact and has no abnormalities; and stitch up the episiotomy incision. The nurses monitor Chunhua for two hours to ensure there are no further complications before she is wheeled out of the delivery room and back to the patient wards.

Chunhua's experience is representative of the typical woman's childbirth process through Jiangbei Central Hospital—one marked as a medical event with a set of standardized procedures. As we see in Chunhua's journey, childbirth is not simply a physiological act, but is also a biosocial phenomenon that, as anthropologist Brigitte Jordan writes, is "produced jointly and reflexively by (universal) biology and (particular) society."⁶⁵ In particular, the impetus of government directives in China to modernize the traditional birthing system has driven an originally private, largely non-medical affair, taken care of at home with *jieshengpo*, to one efficiently managed as a medical issue by obstetricians and nurses. Childbirth thus comes under

⁶⁵ Jordan and Davis-Floyd, *Birth in Four Cultures*, 3.

the authority of medical professionals in the name of health. However, as I argue in this chapter, even as biomedicine safeguards health, it simultaneously acts as a risk-management strategy to control the unpredictability of women's bodies and the process of labor. Both women and physicians, therefore, come to view the cesarean section, as a way to manage the *possibility of* illness and injury rather than its actual presence.

Obstetrics: Surveillance and risk management

In the medical model of birth, pregnancy and labor are viewed as potentially risky—something could negatively affect the mother's or baby's health, justifying constant surveillance and potential for medical intervention. As we see in the OB/GYN department at Jiangbei, this process of surveillance occurs early and often. Chunhua is sent for urine, blood, ultrasound, or other forms of prenatal testing so that physicians can monitor and assess her for any risk. If she deviates from the norm, as determined by biomedical markers and surveillance technology (blood sugar, blood pressure, ultrasound etc.) her record is marked with a color-coded sticker ranging from green (low-risk) to red (high-risk). The higher the risk, the greater the risk of death or injury without medical intervention.

However, if prenatal appointments are discrete points of surveillance during a woman's pregnancy, admission into hospital in-patient wards is the transition into the height of monitoring and potential for intervention. In Chunhua's experience, obstetricians and nurses monitor her belly with fetal stress tests and electronic fetal monitors that track the baby's heart rate on a paper print-out. Her cervix is checked every two hours to see how much it has dilated. If her labor is progressing too slowly, the medical professionals, fearing that the baby may be deprived of oxygen, may break her water or administer oxytocin, an intravenous medication that strengthens

contractions and speeds up labor.⁶⁶ If they see any indication of fetal distress on the electronic fetal monitor, they may decide to do an emergency C-section. Therefore, birth becomes a constant process of risk calculation, governed by surveillance medicine and technology.⁶⁷

Delivering successfully

Women have come to accept and internalize this medical model of childbirth, allowing their bodies to be monitored and managed by biomedicine. However, the predominant risk discourse brought about by medicalization leaves them constantly aware of their vulnerability. In particular, many women focused their anticipation and experience of childbirth on being able to “deliver successfully,” or being able to birth the baby vaginally without resorting to an emergency cesarean section.⁶⁸ Ideas of what constituted a good birth, therefore, revolved around notions of risk and risk-assessment. When I asked antepartum and postpartum women whether they preferred vaginal or cesarean delivery, the overwhelming majority believed vaginal delivery was better for the baby and mother. All of them understood that a vaginal delivery allows for faster recovery, and that cesarean deliveries cause greater harm to the body, increase the length of hospital stay, cause a larger loss of blood, and leave a scar. Some also added that babies born vaginally would have fewer respiration problems, better immunity, and greater intelligence or better behavior. In terms of absolute terms of health, a vaginal delivery was better.

However, despite this consensus, many women stipulated that vaginal delivery was only possible if it was completed successfully and if one’s body conditions were right. In particular,

⁶⁶ Cunningham et al., *Williams Obstetrics* 24/E.

⁶⁷ Skolbekken, “Unlimited Medicalization? Risk and the Pathologization of Normality,” 18–19.

⁶⁸ Arney, *Power and the Profession of Obstetrics*; Lazarus, “Theoretical Considerations for the Study of the Doctor-Patient Relationship.”

many women distrusted their own bodies, seeing it as a site of risk.⁶⁹ Lanying, a 26-year-old first-time mother, preemptively requested a cesarean section because she felt like she was too overweight, despite the fact that the doctor encouraged her to try for a vaginal delivery. Her husband, Jing, told me:

If you're a bit on the larger side, it would be more difficult to labor. And certain things might not go smoothly. Typically if you're skinny, it's more convenient and easier to choose a vaginal delivery. If you're fat, the labor process might be long. Once you use up all the energy in labor you might not even have the energy to give birth at the end. It depends on the person...Our thinking revolves around her body and health.⁷⁰

Even women who chose to have a vaginal delivery felt like something was wrong with them if they were not progressing in their labor. They feared the baby would be stuck in their bodies for too long and suffocate. An, a 25-year-old from Sichuan province, had requested a cesarean before labor because she worried about her baby's health. She told me she thought cesareans were safer because "if you give birth yourself, you might not deliver successfully...If you labor a long time, it might be dangerous to your baby's health. And there's also a possibility of hemorrhaging."⁷¹ Despite her fears, doctors told her she had to deliver vaginally, which she eventually did. Chunhua, who likewise contemplated getting a cesarean during labor but delivered vaginally, told me, "When my cervix wasn't opening, it really brought down my energy and confidence. Because it had been too long. I felt like it wasn't good." She was afraid that "if [the baby] was in [her] belly for too long, he would be deprived of oxygen or there would be a problem with his heart."⁷² In other words, a healthy baby could only be delivered vaginally under particular circumstances—if those circumstances were not right, then both the baby and mother

⁶⁹ Wendland, "The Vanishing Mother," 225.

⁷⁰ Jing Huang. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 15th, 2015.

⁷¹ An Cao. Interview by Eileen Wang. Tape Recording. Shanghai, China. June 30th, 2015.

⁷² Chunhua Gao. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 8th, 2015.

might be worse off. Moreover, women believed that these circumstances were contingent upon their own bodies—bodies that, as anthropologist Emily Martin analogizes, are labor machines that can malfunction or break down at any time and therefore must be managed by a doctor.⁷³

The context in which women learn about childbirth has shaped this distrust of their own bodies. In particular, rhetoric from doctors, TV shows, online forums, prenatal classes, and conversations with women who have already undergone childbirth center around ways to ensure a healthy pregnancy and baby and the bodily conditions in which the baby can or cannot be birthed vaginally. For example, during one of the hospital pregnancy classes, the nurse-midwife Xiuying reassured the women that babies can be birthed vaginally. However, she cautioned, this was contingent on four factors, to which she pointed on the Powerpoint slide: Vigor and Strength; Path of Birth (including width of pelvis and the amount of the mother's flesh); Baby Size; and Mental State. All of these factors depended on the woman's body and her behavior. Li, a 30-year-old from Henan, attended these prenatal classes as a first-time mother. She told me, "Doctors will tell you your situation, and you have to see which they recommend. If you have good conditions, like your baby's in the right position and is smaller, they will tell you to directly deliver vaginally."⁷⁴ Even when the woman's body conditions are "good," however, physicians do not guarantee a successful delivery; they merely tell her that she has a "good chance" that she will have a successful vaginal delivery. Despite this supposed reassurance, the risk that something could go wrong nevertheless instills doubt in women's belief in their ability to give birth.

⁷³ Martin, *The Woman in the Body: A Cultural Analysis of Reproduction*.

⁷⁴ Li Zhang. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 8th, 2015.

Through prenatal classes, consultations with doctors, and talking with friends, women come to adopt the idea that there is a normative standard for how pregnant bodies “should be” for a “successful pregnancy.”⁷⁵ At the same time, they learn to believe that while birth is normal, it is overlaid with what sociologist William Ray Arney calls “pathological dignity,” an the ever-present possibility of something going wrong, depending on the woman and her conditions.⁷⁶ This threatens the experience of what constitutes a good birth—delivering a healthy baby.

Cesarean sections as a site of safety and prophylaxis

Within this medical model of birth, safety becomes the core value upon which childbirth is based. It cannot be dependent on women’s bodies and the uncertain process of natural labor. Instead, one must rely on the precision of medicine and technology, exercised by the medical profession, to guard against the pathological potentiality of childbirth and to ensure the baby’s health.⁷⁷ As anthropologist and obstetrician Clare Wendland’s argues, with cesarean deliveries, the “doctor’s (cultural) body” is “a site of safety” while the “mother’s (natural) body becomes the site of risk: risk to herself, and risk to her fetus.”⁷⁸ This idea was particularly evident in women’s narratives. For example, Meirong, a 24-year-old, second-time mother from Anhui, had come in for a cesarean delivery because of the uterine scar from her first cesarean section. She recounted her first birth, telling me that she had originally wanted to deliver vaginally. But because she was past overdue and the amniotic fluid was discolored, she felt like a cesarean section was a better option for the safety of her child—and a sacrifice that her body had to make for it.

⁷⁵ Douché and Carryer, “Caesarean Section in the Absence of Need.”

⁷⁶ Arney, *Power and the Profession of Obstetrics*, 54.

⁷⁷ Irwin and Jordan, “Knowledge, Practice, and Power,” 326; Lazarus, “What Do Women Want?,” 40.

⁷⁸ Wendland, “The Vanishing Mother,” 225.

Some people want to deliver vaginally, but fear that the child will be deprived of oxygen or choke on amniotic fluid. But with cesareans, they just cut through and take it out. I feel like it's pretty safe for the child. Babies delivered by cesarean are quite healthy and unharmed. It's safer for the baby. It's just that the mother has to '*shou zui*' (suffer).⁷⁹

Likewise, Chenguang echoed this belief:

During the surgery, the doctor is always with you, and if there's a problem, they'll find it. If you deliver yourself, if you '*sheng bu xia lai*' (cannot deliver successfully), then you have to change your entire delivery method to a cesarean. Some people labor for so long and they still don't deliver successfully.⁸⁰

She told me that she had never heard of anything going "wrong" with a cesarean surgery whereas she had heard of many stories of difficult labor with vaginal deliveries. Such attitudes exemplify a certain faith in medicine, science and technology over faith in one's own body.

At the same time, some mothers also come to see cesarean sections as a way to *prophylactically* manage risk before the onset of labor. Risk, as medical sociologist David Armstrong notes, "has no fixed or necessary relationship with future illness; it simply opens space for possibility."⁸¹ Even if there is nothing presently wrong with women's pregnancy or labor, the possibility of future illness transforms pathology into a "point of perpetual becoming." Women come to fear this possibility and might view the cesarean section as a risk management strategy.⁸²

For example, some women felt like they might as well go through the cesarean first rather than what they called "suffering twice," in which a woman who plans a vaginal delivery and suffers through the labor ultimately ends up getting a cesarean.⁸³ This was particularly important for women who felt that their bodies were not conducive to a successful vaginal delivery, such as

⁷⁹ Meirong Wu. Interview by Eileen Wang. Tape Recording. Shanghai, China. June 17th, 2015.

⁸⁰ Chenguang Wang. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 8th, 2015.

⁸¹ Armstrong, "The Rise of Surveillance Medicine," 401.

⁸² Armstrong., 402; Douché and Carryer, "Caesarean Section in the Absence of Need."

⁸³ Kuan, "'Suffering Twice,'" 407.

if they were too fat; if their babies had grown too big, over 4kg (or 8.8 pounds); or if they felt like they had a pelvis that was too narrow. Lanying told me, “I don't want to experience suffering twice. I fear in case I labor and I can't deliver successfully, then I have to get a cesarean anyway.”⁸⁴ They emphasized that they only chose a cesarean because the risk of an emergency cesarean section was too high; however, if she was “as skinny as [I was]” they would clearly choose a vaginal delivery. Risk provided a gray space for the decision, leading them to preemptively request the cesarean section.

Risk for physicians

Within the medical model of birth, physicians and nurse-midwives are active players in the childbirth process. They are held accountable for safeguarding health and as a result, their actions are similarly pressured by notions of risk. Indeed, when I asked Dr. Li, the Chief OB/GYN who had been practicing for 25 years, whether she enjoyed being an obstetrician, she sighed and told me:

Now looking back on [my choice to become an obstetrician], there's too many risks with obstetrics. I just think that now I'm doing it, it's too emotional. My heart often drops. For example, if the fetal heart rate drops, our hearts also drop. When the baby or the mother has some kind of problem, it's often urgent.

She recounted how her most nerve-wracking experiences as an OB/GYN was being alone on a night shift:

There was one time when I was using forceps in this delivery room. The person's second stage of labor was too long, and when I checked, I saw her baby was not in the right position—its face was to the ceiling. So I used the forceps. But the baby wouldn't move. The forceps slipped twice or three times. I thought at the time that the baby was going to die. It was just me on night shift, and it was a very dangerous situation. But eventually I pulled the baby out. When the baby came out it was asphyxiated, so it was transferred to

⁸⁴ Lanying Huang. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 15th, 2015.

a tertiary hospital with a neonatal care unit. I was getting ready for this family to sue me.⁸⁵

Even an experienced physician like Dr. Li, who has had more training than some of the younger doctors in managing vaginal deliveries, fears not being able to deliver a healthy baby. In the case in which women “hand over” their bodies and babies to the physician, they expect safety and optimal health. If the unpredictability of labor derails this health—such as if the baby is asphyxiated—the doctor is held accountable for not being able to prevent it. This was particularly stressful for all of the nurses and doctors who were keenly aware of the growing patient dissatisfaction in China and the possibility of patient violence against doctors.⁸⁶

For Dr. Li, the burden of responsibility is higher with vaginal deliveries—something that required constant monitoring and judgment. On the other hand, cesarean surgeries are more straightforward, more controlled, and less unpredictable. As Dr. Li told me, “In fact, doing cesareans is not hard at all. What is harder is examining stages of labor. Cesarean section is just a bunch of steps; if you do it all, then it's all good.”⁸⁷ This was echoed even more prominently among the younger doctors. Dr. Zhang, who had only been practicing for six years during the years of high rates of cesarean sections, felt like she was more comfortable with handling cesarean sections. She told me:

It's a vicious cycle. The fewer vaginal deliveries, the less experience doctors will have with them. The doctor's ability to manage labor also decreases and then they do not have the self-confidence to judge a vaginal delivery. So they opt for a cesarean, and then there's even fewer vaginal deliveries.

⁸⁵ Dr. Jing Li. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 7th, 2015.

⁸⁶ In China, patient grievances over poor care, medical errors, or exorbitant costs in the absence of efficient legal channels for malpractice lawsuits have led to increased incidences of threats and violence against doctors. The larger issues underlying this phenomenon are beyond the scope of this thesis. For more information, see: Hesketh et al., “Violence against Doctors in China.”

⁸⁷ Dr. Jing Li. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 7th, 2015.

Both mothers and physicians share the same fear of risk in childbirth. For the mother, the pressure is to ensure her body is conducive to a healthy delivery; for the physician, the pressure is to successfully deliver the baby. In both cases, they share the idea that technology can safeguard the baby from an outcome they want to avoid: a potentially detrimental labor—even if they both agree the absolute benefits of a vaginal delivery are greater.

Medical authority over childbirth

In the previous sections I have mentioned that women come to adopt the notion that their bodies are potentially pathological and that biomedicine can control the risk to their babies. The biomedical model of birth, promoted by the state,⁸⁸ transforms the woman into a “patient” in a place typically seen as a place for illness or suffering. She hands over her trust of how to handle childbirth to the physician which, in turn, creates a hierarchical distribution of knowledge and power that positions the doctor as the authoritative decision-maker over the woman’s delivery.⁸⁹

In China, the doctor-patient relationship most closely resembles a paternalistic model in which physicians are presumed to be in the best position to judge what is best for their patients—making treatment decisions and recommending or ordering patients to consent.⁹⁰ At Jiangbei, most women exhibited almost complete deference to such medical authority. On the other hand, doctors would often suppress women’s questions by telling them whatever they were doing was for the “health of their baby.” If this authority was violated, doctors would reprimand the mother. For example, while I was in the outpatient department, I saw a young woman show Dr. Zhang her blood pressure slip, which was high – 141/90.

Dr. Zhang: “Did you record your blood pressure exactly like we showed you?”

⁸⁸ See Chapter One on state authority over birth.

⁸⁹ Jordan, “The Hut and the Hospital,” 39.

⁹⁰ Hui, “The Centrality of Patient-Physician Relationship to Medical Professionalism.”

Mother: “Well, I saw that it was normal, so I just didn’t write it down anymore.”

Dr. Zhang: “Then you might as well have not come to this hospital, if you don’t listen to what we say! If you continue this, it could hurt both you and your baby.”

It turned out that once the woman saw her blood pressure was normal, even lower than normal, she only bought and took half of the pills prescribed. Subsequently, her blood pressure rose again. This frustrated Dr. Zhang, who saw that her “noncompliance” threatened the health of her pregnancy which would have otherwise been safeguarded by her directions.⁹¹

Granted, these kinds of paternalistic interactions are exacerbated by the lack of patience and time doctors have. At Jiangbei, doctors see almost 60-70 women per day in the outpatient department; watching Dr. Zhang, I often felt like I was situated in a well-oiled machine, which, while efficient, left little room for empathy. In an environment where health was prioritized within certain time constraints, physicians had no time to deal with issues of trust or address the humanistic aspects of health care.

This power dynamic intensified when women were admitted to the in-patient department, and thus, totally subsumed under the control of medical authority and their medical interventions. As I was interviewing Jinghua, a 27-year old woman from Anhui, one of the residents came in and told her, “We need to break your water to check your fluid, to make sure it is okay. Sign here.” The resident gave her a sheet of paper, presumably with information about the procedure, but neither explained what they would do nor wait for her to read it. Jinghua signed it without giving it a glance and handed it back. Once the resident left, Jinghua remarked that she did not really know why they were breaking her water, upon which the postpartum

⁹¹ Trostle, “Medical Compliance as an Ideology.”

woman next to her in the room explained that it was to make sure the baby was not deprived of oxygen.

Later, I accompanied Jinghua to the labor room, at which point her cervix had dilated to two centimeters, and she was having contractions every 7-8 minutes. She lay on the bed, her hips resting on top of a disposable absorbent bed mat. Dr. Jia, a young OB/GYN resident, used a small tube to probe through her vagina, and at once, fluid started rushing out onto the mat. Dr. Jia immediately made a grimace, shook her head and said out loud, “The amniotic fluid is not so good.” She proceeded to reprimand Jinghua for not coming sooner, as she was already two weeks overdue. She then said briefly, “You will need a surgery.” Jinghua was silent, and remained passive as Dr. Jia further probed around her cervix with her gloved hand. She removed her hand and then proceeded to the nurse’s station, calling someone on the phone, “I need to do a cesarean immediately!”

There was absolutely no discussion of the consequences of a cesarean or other options. In cases of what doctors deemed “medically necessary,” the doctor did it without regard to the woman’s own experience of her body. When I asked Jinghua why she did not come to the hospital earlier, she said it was because she had not felt any labor pains yet, so she did not see the need. In other words, by listening to her own subjective experiences instead of coming under the safety of medical professionals and their technology, she endangered her baby.⁹² The only explanation Jinghua received was from a nurse: “Because your baby's amniotic fluid is not so good, if your baby's in there too long, it's not good for it. Your baby's heartbeat might drop. Okay? It's dangerous. That's why we're doing the surgery, okay?” The nurse asked her to sign a series of forms, which she did obediently.

⁹² Wendland, “The Vanishing Mother,” 225.

Even when a woman was on the delivery table, the nurse-midwives would often maneuver her body into the “correct” position. They would tell her to open her thighs or to keep her back pressed to the table, and if she did not listen, they would push her legs or body down. They would also tell her when and when not to push. In one instance, I watched as the midwife, not yet prepared to catch the baby, tell the woman to stop pushing. The woman continued to push, and at this point, Fang, other attending midwife, strided to the woman’s head to tell her to stop. The woman replied, “Not possible!” unable to resist her physiological urges. Fang, who had been a labor and delivery room nurse for five years at Jiangbei, justified their method of directing women a little later,

You have to look after the woman's well-being. You have to make sure they are listening to us telling them how to push. To do it gently. To not push, to rest. If they push the baby out too quickly they'll stretch and tear their vaginal canal.⁹³

She talked about how some patients do not listen, or are dissatisfied with the nurses and doctors, despite the fact that doctors were simply doing “what was good for them,” for their health and safety. In their eyes, doctors had women’s best interests in mind. Fang noted:

They aren't satisfied with us. Sometimes we are really busy and our attitudes toward them are slightly impatient, but the way we treat them is for their benefit. But they may not understand. Sometimes they do not cooperate with us. For example if during delivery we tell them to press their back against our hands or to spread their thighs open, sometimes they just won't do it. But if birth was based on their own way of doing things, then it could harm them. They might not understand that. And then they feel like we don't have good manners.⁹⁴

This mentality that doctors know best was clear not only in the doctor-patient interactions, but also in many women’s own perceptions of childbirth. In fact, I often heard women asking doctors and nurses whether they thought they could deliver successfully. When I inquired about women’s own beliefs about vaginal or cesarean delivery, some of them responded

⁹³ Hua Liu (nurse-midwife). Interview by Eileen Wang. Tape Recording. Shanghai, China. July 14th, 2015.

⁹⁴ Ibid.

that they did not even understand and left that judgment to the doctor. As Jinghua admitted to me before her labor, “I don’t really understand [what’s going on]. In any case, I’ll listen to what the doctor says. So if the doctor wants me to deliver vaginally, I deliver vaginally. If the doctor can’t help me deliver vaginally, I can only resort to a cesarean section.”⁹⁵ Lian, a 28-year old third-time mother stated, “After all, you are giving birth in this hospital and you are handing over your life and your baby’s life to your doctor. Of course your doctor is going to be responsible. So if the doctor recommends [vaginal or cesarean delivery], then it is better than what you yourself think. After all, you don’t understand medicine, and they are the specialists.”⁹⁶ Lian had already internalized what was in her realm of control and what was not. She was socialized into the process of medicalized childbirth, leading her not to question medical authority.⁹⁷ However, despite this generalization, I will concede that some women, namely those of upper-middle socioeconomic status, do manage to wield some agency and overcome medical authority by successfully requesting cesarean sections against physician recommendations—something I will elaborate upon later. But for the majority of women at Jiangbei, their own control over the childbirth process is restricted entirely by the medical profession.

In this chapter, I have shown how the medical model of birth highlighting the risk of labor has been incorporated into women’s conceptions of birth, such that they fully accept medical management. Likewise, physicians face pressures to deliver a “healthy” baby. For both actors, the cesarean section is seen as a way to manage risk and control the unpredictable childbirth process. In the next chapter, I explain how the C-section’s appeal of control applies not only to the baby’s safety and health but also to the woman’s suffering during labor.

⁹⁵ Jinghua Zhou. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 14th, 2015.

⁹⁶ Lian Cui. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 30th, 2015.

⁹⁷ Irwin and Jordan, “Knowledge, Practice, and Power,” 327.

III

The Politics of Pain and Pain Relief

“I can’t do this! I can’t give birth! It already hurts so badly and my cervix hasn’t even dilated!” Huifen, a 20-year-old from Henan province, cried out from her hospital bed. The doctors had administered oxytocin to induce contractions, as she was past due and had not yet begun to labor. As the contractions strengthened, she started crying and screaming at the nurses in the labor room.

Dr. Li, in charge of the labor and delivery room that day, checked her belly and told her not to yell and waste her energy. She said to Huifen, “No woman has not had pain,” before turning to me, shaking her head. “This woman has no confidence in herself.”

When Huifen was at two centimeters dilated, she begged Dr. Li to give her pain relief. However, she was not yet in active labor, so Dr. Li said she could not give her an epidural. So Huifen asked Dr. Li, instead, to do a cesarean. Dr. Li told her no, that she should cope with it and that she could deliver vaginally if she put her mind to it. Huifen phoned her family members, waiting on benches outside the labor and delivery ward, but they could not do or say anything to relieve her suffering. She then spoke to her husband on the phone and told him that she wanted a cesarean. Huifen’s husband approached Dr. Li several times and pleaded that she perform the cesarean for Huifen, which Dr. Li also refused. After enduring the pain for a few more hours, Huifen’s cervix fully dilated, and she was able to deliver her baby vaginally.

When I interviewed Huifen before her labor, she told me she wanted to deliver vaginally because she knew that it was better than cesarean delivery, with fewer reproductive consequences and postpartum pain. But after she had given birth, I asked her why she had changed her mind. She told me, “All I was thinking was, what can I do to stop the pain? What

can I do to make this go faster?”⁹⁸ The pain was so bad she could not tolerate it, making her no longer want to deliver herself. Even though she knew the consequences that came with a cesarean delivery, in the moment, she was willing to do it since she knew that they would give her anesthesia during and pain medication after the cesarean. On the other hand, she could not receive the epidural analgesia for her labor pain, because her cervix had not yet dilated past three centimeters—a restriction on pain relief I will elaborate further below. Still, looking back on her vaginal delivery experience, Huifen was grateful that Dr. Li refused to do the cesarean, because otherwise she would have regretted the surgery and suffered through the slow and painful recovery process.

Huifen’s childbirth experience exemplifies my argument in this chapter: that the sociocultural context in which women give birth shapes their experience and expression of childbirth pain, as well as the negotiation of its relief with a cesarean section. Labor pain is not merely the physiological stimuli caused by uterine contractions and cervical dilation; rather, as *William’s Obstetrics*, the textbook used as the basis for obstetric training around the world, states, “these stimuli are modified by emotional, motivational, cognitive, social, and cultural circumstances...cortical responses to pain and anxiety during labor are complex and may be influenced by maternal expectations for childbirth, her age and preparation through education, the presence of emotional support and other factors.”⁹⁹ I contend that pain here, particularly labor pain, is socially constructed, and the woman’s perceptions of her pain and her pain-related behaviors are culturally defined.¹⁰⁰ In what follows, I will describe how both the hospital and cultural environment in which women like Huifen give birth shapes how they conceptualize

⁹⁸ Huifen Xu. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 16th, 2015.

⁹⁹ Cunningham et al., *Williams Obstetrics* 24/E, 54.

¹⁰⁰ Callister et al., “The Pain of Childbirth,” 146.

childbirth pain. The cultural norms of pain expression and lack of medical pain relief constructs a landscape in which women must undergo a double labor: the physical labor of birth as well as the cultural labor of negotiating pain relief in a culturally- and medically-restricted environment. Within this medicalized setting, the request for a cesarean becomes an expression of pain, and a call for a response. Finally, I will argue that while women view cesarean sections as a way to control their experience of pain, the recent state policies—and the physicians who operate under them—view pain as an irrelevant factor in medical decision-making, as it does not promote the larger goal of health.

The anticipation and experience of pain and suffering

Women at Jiangbei feared labor pain and childbirth. Pain, other than risk and health, constituted the large majority of women's descriptions of their anticipated and lived childbirth experience, exacerbated by what their friends or family members told them about the intensity and inevitability of labor pain. Moreover, many women felt that there were no effective ways to decrease the pain. They saw it as an unavoidable part of childbirth, and that they had little agency to change that. Chunhua, a 30-year-old from Henan, had already delivered once vaginally for her first child, but like Huifen, cried out for a cesarean while laboring with her second child. Afterwards, Chunhua told me, "There's no way of enduring it! Of course childbirth is going to hurt. You can't avoid it. You can't do anything about it."¹⁰¹ Most women did not know of any techniques to relieve pain and would look to the physicians and nurses to tell them how to cope while they were laboring. Huifen, after delivery, said, "When you go to the hospital, the doctors and nurses will tell you: when it hurts, just breathe. They didn't teach us how to ease the pain.

¹⁰¹ Chunhua Gao. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 8th, 2015.

They just told us when it hurt, to breathe in through our nose, out through our mouth.” Laughing a bit she added, “I felt like it just made it even more painful.”¹⁰² She sought those who were presumably “knowledgeable” about childbirth—the doctors and the nurses—but found that they were of no help in the area of pain management.

Still, while many women saw labor pain as an unavoidable part of vaginal birth, some did believe that they could potentially avoid it with a cesarean section. For example, Lan, a 29-year-old who was at Jiangbei Central Hospital for her second cesarean, had requested a cesarean for her first child back when the doctors were not as stringent about who could get cesareans. When I asked her why she did so, she told me she did it for the fear of pain: “I was young at the time. When people told me about labor pain, of course I would feel that way.”¹⁰³

Conceptual differences: labor pain versus cesarean pain

Given that labor pain was a major reason women would request or think about requesting a cesarean delivery, did such women not also consider the experience of cesarean pain? After all, recovering from a cesarean delivery was not a painless process. Women often lay wooden in bed, unable to flip over. They could not even walk to the bathroom without leaning upon a family member and shuffling to the door. Furthermore, doctors and nurses would often come into the ward and, without warning, press vigorously on the woman’s surgical wound to squeeze out any excess residue in the womb. I would grimace in empathy as the woman’s screams would pierce through the hospital. Why would women fear labor pain, when cesarean pain, as I saw it, seemed just as painful? Was there a conceptual difference between the two types of “pains” if, indeed,

¹⁰² Huifen Xu. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 16th, 2015.

¹⁰³ Lan Hu. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 30th, 2015.

pain was merely a physiological phenomenon? And if so, how did the social context construct this difference?

Women clearly distinguished between the two childbirth pains, providing a key delineation between vaginal and cesarean delivery. Chenguang, who chose to have a cesarean for her first child because she feared the labor pain, told me,

In any case you have to hurt either way. With both choices you have to suffer. But with surgery they use anesthesia and give you analgesia afterwards. They just say that if you deliver yourself of course you're going to hurt and hurt until you finally give birth. So I thought about it, and I felt that a cesarean would be better.¹⁰⁴

Similarly, Daiyu, whom I described in the introduction, told me:

Typically when you give birth, there's just two ways of doing it: vaginally or by cesarean. In any case they say that cesareans don't hurt. They give you anesthesia. I don't know what that pain feels like when the anesthesia wears off, but it's just that when you're giving birth it doesn't hurt.¹⁰⁵

Hua, a woman who had given birth by cesarean for her first child further distinguished the two pains: “If I were delivering, I have to lie down over there, and suffer in pain. Cesareans—once they do a surgery, it hurts afterwards but then it gradually lessens in pain. So we don't dread it as much. But when I am lying in the patient bed, I dread the pain.”¹⁰⁶

In these responses, I saw that women defined pain by how and when it would be relieved, rather than, for example, conceptual differences in “natural” versus surgical pain. First, women viewed surgical and labor pain by the way each is managed by pharmaceutical methods. On one hand, surgical pain was manageable because physicians administered anesthesia during the surgery and pain analgesia during recovery. On the other hand, labor pains were something to be endured, as physicians administered no pain analgesia during labor, which I will elaborate

¹⁰⁴ Chenguang Wang. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 8th, 2015.

¹⁰⁵ Daiyu Yang. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 22nd, 2015.

¹⁰⁶ Hua Lian. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 14th, 2015.

further below. This further exacerbated women's view that labor pain was something unavoidable and uncontrollable.

Second, women did not see pain as just a physiological experience; they marked pain by the length of time it was to be withstood. In the case of labor pain, the time when relief would come was uncertain—it could be one hour or eight hours depending on the progression of labor and birth. Indeed, those who requested cesareans in the midst of labor told me they felt like they could not handle the pain anymore, particularly if they had been laboring for a long time. On the other hand, post-surgical pain was predictable—women knew it would hurt, but they knew the pain would lessen within a week, managed by analgesia.

Lack of pain relief during labor

How did labor versus cesarean pain come to be constructed in these particular frameworks of pain relief? If there was effective pain relief during vaginal delivery, perhaps this distinction would not have been so strong. In fact, I noted that none of the women mentioned pain analgesia or epidurals¹⁰⁷ as a way to relieve their pain during labor. According to the nurse-midwives, pain relief during labor is uncommon in China, and at Jiangbei Central Hospital, only 7-8% of women receive epidurals for reasons I will explain below.¹⁰⁸

A majority of women told me that they had no idea that pain relief was available for vaginal delivery. Some were even surprised or confused when I told them that epidurals existed; they had always associated pain relief with cesarean deliveries. As one woman said, “here in

¹⁰⁷ The phrase the Chinese use is “wu tong” or painless delivery. I translate the term as “epidural.” In reality there are other methods of pain analgesia during labor, but epidurals are the most common and popular form of pain relief during labor, particularly in countries like the US.

¹⁰⁸ A few tertiary hospitals in Shanghai are starting to implement 24/7 epidural services, which has increased the epidural rate for women there to as high as 70-80%. However, such practices are still uncommon in greater China.

China, from when we were little we were taught it is either natural delivery or cesarean delivery. There's nothing else. The doctor didn't even mention it. Traditionally it should be a natural delivery.”¹⁰⁹ However, when I asked women if they would want an epidural if it were available, most women said yes. Some who had thought about requesting or had requested a cesarean for pain said that they would not have done so if there was effective pain relief during labor.

Even if a woman did know an epidural was available at Jiangbei and requested one, she was more often than not denied it. One woman told me she had asked a nurse about the possibility of pain relief. The nurse said that it was possible, but she would have to wait to ask the doctor about it. However, when she asked the doctor, the doctor responded that such a thing did not exist for vaginal delivery. Again, the unavailability and denial of pain relief during labor points women to the idea that the only method of pain relief, therefore, is through surgery.

Rationing pain relief: Resource constraints

The politics of pain relief during labor centers on the larger issue of resource constraints. During my interview with Dr. Li in an office adjacent to the labor and delivery room, we were interrupted by loud cries and yells. When she heard this woman yell, she stopped our interview and walked to the crying woman. As one of the few OB/GYNs at Jiangbei who actively sought out epidurals for her patients, Dr. Li asked this woman, Chunhua, if she wanted an epidural. Chunhua yelled, “Yes! I can’t stand it anymore! Just give me a shot!” At this point, the nurse examining her looked at me, rolled her eyes, and told her, “don’t yell, or else you’re going to yell your baby sick.”

¹⁰⁹ Huizhou Zeng. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 6th, 2015.

Dr. Li used the labor room phone to call an anesthesiologist who could potentially do the epidural. “Are you resting today? Okay, sorry about that, I won’t interfere with your rest.” She called two more anesthesiologists, but they were all busy or off work. She finally hung up, and apologized to the Chunhua. “Sorry, there aren’t any anesthesiologists available. You’re just going to have to endure the pain.”

Pain relief was denied to laboring women not just because anesthesiologists were busy, but for various, often overly-restrictive factors: if it was nighttime or Saturday, anesthesiologists would not be available; if the woman’s cervix had not dilated to three centimeters or if the woman’s cervix had dilated too far—past five centimeters—it would be either too early or too late to administer the anesthesia¹¹⁰; or if anesthesiologists failed to properly insert the epidural needle into the spine after a few attempts, they would abandon the endeavor.

I later asked Dr. Li why hospital anesthesiologists would be readily available for cesarean sections, but not epidurals for laboring women. She said that they viewed addressing this kind of pain as “optional” and that only three out of 20 anesthesiologists at Jiangbei even knew how to administer epidurals, as it had not been fully developed in their specialty training. Therefore, if those three were busy, women were out of luck.

¹¹⁰ Early retrospective studies showed that epidural placement in early labor (before 3-4cm) was linked to an increased risk of cesarean delivery, but more recent randomized trials have shown that timing has no effect on the risk of cesarean birth, forceps delivery or positioning of the fetus. However, in China, such epidurals are still withheld until after 3cm. Conversely, studies have shown that those who had cervical dilatations of more than 7cm when they received epidural analgesia were more likely to have had inadequate pain relief. More research should be done on how physicians judge the timing of epidural placement (as well as their beliefs about pain relief) in China. For more information see: Cunningham et al., *Williams Obstetrics 24/E*. and R. Agaram et al., “Inadequate Pain Relief with Labor Epidurals: A Multivariate Analysis of Associated Factors,” *International Journal of Obstetric Anesthesia* 18, no. 1 (January 2009): 10–14, doi:10.1016/j.ijoa.2007.10.008.

Dr. Zhang told me that there were too many patients (and too many people, in general) in China, and not enough doctors and anesthesiologists.¹¹¹ Therefore, anesthesiologists were reluctant to monitor a patient for 10-20 hours during labor, whereas a cesarean could be done in one hour: “If there’s a problem [with the epidural during the long labor], then they have to take the responsibility. They don’t want to do it. It’s not efficient.” As an accumulation of these factors, doctors often do not mention the option of pain relief, let alone give it to women.

The scarcity of pain relief during labor points to the idea that the state-run hospitals prioritize labor pain less than other types of pain, particularly in an environment in which anesthesiologists, and doctors in general, are in short supply. Pain relief is rationed to procedures like the cesarean section or surgery that aim to safeguard health—not to relieve the suffering of “natural” childbirth.¹¹² Indeed, in the pamphlets disseminated by the Shanghai municipal government promoting “natural delivery,” nowhere do they suggest pharmacological methods of managing labor pain nor ways women can better handle labor pain. Instead, they merely list the health benefits of “natural delivery” (See Appendices 1 and 2). The fact that public health officials and providers see “natural childbirth” as better, but within a medicalized context without providing pain relief, reveals a disconnect between what women want (to relieve suffering of childbirth) versus what the state thinks is a priority (ensuring the health of the baby). This disconnect shapes the rationing of pain relief that, first, leads women to believe that cesarean deliveries are the only way to reduce the pain of childbirth and, second, to use cesarean sections to control their pain.

¹¹¹ Such a shortage may, in part, be precipitated by physicians’ own dissatisfaction with the profession, particularly due to its low-paying salary compared to other jobs, the deteriorating doctor-patient relationship, and incidences of violence against doctors. These are larger underlying issues in the Chinese health-care system that are beyond the scope of this thesis.

¹¹² As I mentioned in the introduction, the common term for vaginal delivery is simply *zi ran chan*, or “natural delivery.”

The dual burden of physical and cultural labor

A 21-year-old second-time mother from rural Anhui, Dongmei went into the labor and delivery room, confident in her ability to deliver vaginally. She was average height, of slight build. Given that she had already delivered once vaginally and her body conditions were conducive to it, she decided that a vaginal birth was better for herself and the baby.

However, once in the labor and delivery room, her labor stalled; her cervix opened slowly, and even when it had opened sufficiently for the baby to pass through the vaginal canal, her child did not budge. At that point, she had been laboring for sixteen hours and was in extreme pain. She cried and yelled, but had no one to lean on or comfort her; her husband and family members were forbidden to enter the labor and delivery room, mainly because the nurse-midwives did not want to have them in an open ward with other laboring women. Moreover, the only people who were there to help, the nurses and doctors, were emotionally unresponsive to her expressions of pain. When she cried or yelled, nurses told her “don’t waste your energy on yelling right now.” When Dongmei told the nurses that she could not give birth anymore, they responded, “Everyone says they can’t handle it anymore, but at the end they still deliver their baby. Who has given birth who hasn’t hurt? It’s all like this. They [referring to the postpartum women] all gave birth, why can’t you?” In traditional Chinese culture, screaming in pain is seen as shameful and something that depleted the body’s energy for the final stages of birth; at the same time, women had to learn to accept suffering, suppress its expression, and rely on themselves to get through it.¹¹³ Dongmei told me:

When I was in pain in the labor and delivery room, I would yell and no one would pay attention. Then by the time it had hurt even more severely, I wanted to cry but not even one tear would come out. Really, at the time I thought I wanted to die...Everyone [the nurse-midwives] wanted you to give birth yourself. And they would just chat, talk to each other,

¹¹³ Cheung, “The Cultural and Social Meanings of Childbearing for Chinese and Scottish Women in Scotland”; Callister et al., “The Pain of Childbirth,” 148.

and make jokes. And it was just me, alone, suffering - no one paid attention. At that time, I lost hope because there was not one person to comfort me. I felt like I didn't want to give birth anymore.¹¹⁴

Anthropologist Talal Asad notes that pain is a relationship: “Suffering is partly constituted by the way [the sufferers] inhabit, or are constrained to inhabit, their relationship with others.”¹¹⁵ To this, medical historian Julie Livingston emphasizes from her ethnographic work on pain in a Botswanan cancer ward: “Pain begs a response.”¹¹⁶ Dongmei’s cry out in pain was a claim asking for acknowledgement and for a response.¹¹⁷ However, in the labor and delivery room, neither her family members nor nurses were either physically or emotionally available to respond to Dongmei’s pain. The nurses were inured to these cries as women’s suffering had become so routine to them; and even if they were aware that women like Dongmei were in pain, they were powerless to address it. The nurses, many of whom requested cesareans for themselves out of fear of pain, told me they supported the use of epidurals. However, given its lack of availability, the nurses believed they could not really otherwise address the labor pain. For Dongmei, however, this lack of attentiveness translated into the perception that the nurses did not care for her, further contributing to her suffering.

The request for a cesarean section: an expression of pain and call for a response

Dongmei thus possessed a double burden: not only did she have to undergo the physical labor of birth, but she had to negotiate some form of relief to her suffering and pain in a context without family members, pain relief (she did not even know epidurals existed), or a culturally-appropriate way to express or seek help for her pain. Within the context in which no pain

¹¹⁴ Dongmei Liang. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 15th, 2015.

¹¹⁵ Asad, *Formations of the Secular*, 85.

¹¹⁶ Livingston, “The Next Epidemic: Pain and the Politics of Relief in Botswana’s Cancer Ward,” 185.

¹¹⁷ Das, “Language and Body,” 70.

medication for vaginal delivery was available, she, and other women, immediately jumped to surgery as the solution to her pain. As Dongmei said about her birth experience:

Before, I wanted to deliver vaginally because [after birth] it wouldn't hurt. But then when I entered the labor and delivery room and underwent that labor pain for so long, I couldn't cope with it anymore. I kept on thinking I wanted a cesarean. If I had a cesarean I wouldn't hurt anymore. The pain only comes afterwards, and even then they'll give you some pain analgesia so it wouldn't be as agonizing.¹¹⁸

Despite the fact that Dongmei originally wanted to have a vaginal delivery, she asked the doctor for a cesarean section, thinking it could relieve her in-the-moment pain—a pain she could not cope with alone. I saw this request as what Livingston calls “an economy of expression” within a context in which cries of pain are to be suppressed for the good of her baby.¹¹⁹ The cry for a cesarean also acted as the “communicative possibility that will bring relief to [her]” in a medicalized system of childbirth without social support, which could otherwise act to reduce the use of medical forms of pain relief.¹²⁰

Still, Dr. Gao, the Chief OB/GYN in charge of the labor and delivery room that day, rejected this claim, knowing Dongmei wanted it to relieve her suffering. She would tell her or other women who similarly asked for a cesarean section, “Pain is not an excuse.” “Why do you want one? It’s bad for you, and you have no medical indication!” I noted that instead of providing support to alleviate some of the suffering that led Dongmei to request the cesarean, doctors merely acted as gatekeepers towards medical intervention, thus instantiating the view that labor should be a solitary endeavor dependent on one’s own confidence and willpower. In fact, it was not until Dongmei’s cervix had dilated all the way to ten centimeters, and the baby

¹¹⁸ Dongmei Liang. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 15th, 2015.

¹¹⁹ Livingston, “The Next Epidemic: Pain and the Politics of Relief in Botswana’s Cancer Ward,” 188.

¹²⁰ Ibid., 187, 195; Hodnett et al., “Continuous Support for Women during Childbirth.”

still had not come out after three hours—an indication that the baby may be stuck and could be deprived of oxygen—that Dr. Gao only decided to do a cesarean section.

From what I gleaned from the doctor-patient interactions, physicians and nurse-midwives did not see pain as a valid excuse for a cesarean section. As nurse-midwife Wen told women during a prenatal pregnancy class about the methods of delivery: “you have to think about the harms and benefits. Which provides the most benefits and least harm in this situation? *Not being able to stand the pain is not a reason.* You can’t just say, oh it hurts too much, just give me a cesarean--there’s no point in that. Think of yourself and your fetus”¹²¹ [emphasis added]. The role of the physician, by refusing these requests for cesareans, is to protect the woman from the consequences of surgery. This physician refusal is further reinforced by broader state policy restricting such “unnecessary” cesarean surgeries. Thus decisions in childbirth, controlled by the physician and state, prioritize health rather than the experience or desires of the woman (to control pain for example) during childbirth.

Still, I note that the problem is not that Dr. Gao refused the cesarean section; the problem is that, as a medical professional with numerous women to attend to, she could offer a very limited *kind* of help to the experience of the laboring woman. Doctors have medical tools geared towards the baby’s delivery, but offer no general social support for laboring women in pain—roles that midwives and family members traditionally fulfilled.¹²² In this version of the medical model of birth, social care was nowhere to be found. And even when medical care was

¹²¹ Xiuying Wen (nurse-midwife director). Observation of prenatal pregnancy class. Tape Recording. Shanghai, China. June 23rd, 2015.

¹²² Fox and Worts, “Revisiting the Critique of Medicalized Childbirth,” 338.

In China, doulas, or birth companions that assist and provide emotional support to the woman particularly during labor, are becoming more popular in fulfilling this type of role. While they are not currently available at secondary-level hospitals like Jiangbei, I did see them at larger, tertiary hospitals—however, they had to be purchased with a private room for a substantial fee.

omnipresent—to which women looked for help to relieve the suffering of childbirth—it was a type of care that was not accessible to them.

In this chapter, I have discussed how the sociocultural context in which women give birth constructs their conceptualization of childbirth pain, as well as how they negotiate, ask and receive assistance for it. In particular, women attempt to request cesarean sections to relieve their suffering during labor in the absence of effective pharmacological pain relief. On the other hand, physicians reserve cesarean sections for “medical” indications, which is further reinforced by the recent state policies. Given their perceived inability to do anything else to relieve the physical pain, they become inured to these cries for biomedical relief which, in some sense, further contributes to the social aspect of pain and suffering. In the next section, I will discuss how some women overcome state and physician control over notions of pain, health and risk in childbirth to receive their desired cesarean delivery. Although I have touched upon state-doctor-patient interactions in previous chapters, I will use them as a focal point to show how cesarean deliveries are negotiated.

IV

Choice, Control and Decision-Making

In the context of China, I have thus far noted that women may request cesareans, viewing them as a site of safety, or as a way to relieve the suffering of childbirth—perceptions shaped by their social context.¹²³ I have also shown how the state and medical profession possess substantial authority over childbirth and reproductive processes. In this chapter, I elaborate upon the hierarchy of state and medical authority at the point of cesarean delivery decision-making, particularly given the recent regulations circumscribing CDMR. However, I argue that some women nevertheless are able to successfully request cesareans and exhibit agency and control over the childbirth process. Such women are often of high socioeconomic status and wield the economic and social capital to convince the physician to deviate from her “scientific judgment”; on the other hand, those who do not possess that capital continue to be subject to medical and state authority.

Cesarean decision-making: The physician-state-patient relationship

As I noted previously, in the medical model of birth, physicians possess authoritative knowledge and therefore decision-making power over a woman’s delivery method. As anthropologist of childbirth Brigitte Jordan writes, the medicalization of birth has produced “new conceptions of what counts as relevant information and new judgments concerning who is competent to interpret information, to communicate it, and to make decisions regarding the

¹²³ McCallum, “Explaining Caesarean Section in Salvador Da Bahia, Brazil,” 23; Lazarus, “What Do Women Want?,” 26, 30.

management of birth.”¹²⁴ Similarly, anthropologist Ellen Lazarus notes that in biomedicine, “the domination [of the doctor-patient relationship] rests on the structural asymmetry of resources: who in the situation controls medical knowledge and technology.”¹²⁵ Cesarean deliveries, in particular, are only made possible by the obstetrician and her surgical tools and technologies; as such, the final decision for surgery comes down to the obstetrician. However, as I will show, the physician’s decision to perform a cesarean are influenced both by state control and maternal agency.

The profession-state relationship

In China, physicians are subordinate to the state in many ways. As sociologist Jingqing Yang has noted, in a socialist country like China, the rise of professions is determined by the central government party according to ideology and state-determined goals.¹²⁶ The medical profession is unable to advocate or protect its interests in face of the state, and the party-state dominates the profession-state relationship.¹²⁷ For example, physicians at state-owned hospitals like Jiangbei are salaried state employees paid by the government, and have little say over their working conditions or levels of pay.¹²⁸ Dr. Li would repeatedly tell me how she sometimes lamented being a doctor, partly because of the low salary which is only 1600 *renminbi* per month, with taxes (around 250 dollars). This income is complemented by bonuses given by the hospital based on the number of procedures she performs, without which she “would not be able

¹²⁴ Jordan, “The Hut and the Hospital,” 39.

¹²⁵ Lazarus, “Theoretical Considerations for the Study of the Doctor-Patient Relationship,” 45.

¹²⁶ Yang, “The Power Relationships between Doctors, Patients and the Party-State under the Impact of Red Packets in the Chinese Health-Care System,” 8.

¹²⁷ *Ibid.*, 22, 47.

¹²⁸ Yang, “The Privatisation of Professional Knowledge in the Public Health Care Sector in China,” 24.

to survive.”¹²⁹ The amount given per bonus are, in turn, determined by how much money the state gives the hospital for being a highly ranked hospital.

Such rankings and subsidies given by the state now take into account factors such as cesarean section rates. With the new policy, the government monitors each public hospital's cesarean section rate. If the percentage goes above a certain threshold, such as 40% for secondary-level hospitals like Jiangbei, then it will cut a portion of the hospital's income and, therefore, doctors' bonuses.¹³⁰ This means that while previously, doctors would be more likely to acquiesce to a cesarean if the woman requested it, particularly as cesarean deliveries are easier to perform and have fewer proximate risks for the woman and her baby than vaginal delivery,¹³¹ now they will no longer do it unless there is a medical indication.¹³² As nurse-midwife Wang Min told me:

Before the rules were looser. In other words - if you know that person, if the mother requests it, or if the mother adamantly says, "I want a cesarean" - then [doctors] will allow it. So then in the cesarean indication box we would write "requested surgery." But right now, everything is stricter. Now it's not like if you want a cesarean you can have a cesarean. You have to have medical indication like macrosomia [excessive fetal birth weight], uterine scar, placenta previa [in which the baby's placenta covers the opening in the mother's cervix] or other medical issues. Before if you requested it they would give it to you. But now if you request it there is no way to give them a cesarean.¹³³

As a result, physicians are subject to state policies that govern their work through state goals and financial incentives or disincentives. According to the providers, they now only perform cesareans for risky vaginal deliveries that may lead to maternal and neonatal morbidity

¹²⁹ Dr. Jing Li. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 7th, 2015.

¹³⁰ Ibid.

¹³¹ See Chapter Two on the medicalization of birth.

¹³² Ibid.; Min Wang (nurse-midwife). Interview by Eileen Wang. Tape Recording. Shanghai, China. July 6th, 2015. See Chapter Two on the Medicalization of Birth.

¹³³ Min Wang (nurse-midwife). Interview by Eileen Wang. Tape Recording. Shanghai, China. July 6th, 2015.

and mortality. Using their medical authority, physicians generally deny women's requests because of labor pain, their mental and psychological incapacity, or fear.

According to doctors and nurses, such state-implemented initiatives have been a public health success. In particular, it has helped Jiangbei lower its C-section rates from as high as 70% in the early 2000s to around 30% today.¹³⁴ While this a remarkable achievement, the numbers do not reveal the ongoing negotiations surrounding childbirth. As I will show in the four cases below, there are numerous exceptions to these regulations for unnecessary C-sections. Women—in particular those of higher socioeconomic status—continue to exhibit agency in this seemingly highly controlled process by successfully asking for, and receiving, cesareans. Their stories reveal how the predominant power structures in cesarean decision-making may be complicated by women's social and economic capital as well as the ambiguities of what constitutes a “scientific” basis to determining a cesarean delivery.

Navigating medical authority

Fenfang: VIP – Very Important Patient

When I was in the labor and delivery room at Jiangbei, I had the opportunity to look at the cesarean section log book from August 1, 2014 to May 31, 2015. As I flipped through the pages, I noted that even though the hospital had already implemented the policy for refusing “non-medical” cesarean deliveries, there were still some entries that listed “requested cesareans” under the “indication” column. Around 90-95% of these women were “*te shu*” (translated as “special” or “VIP”) patients—patients who were staying in private rooms on the 7th floor. Each room was 500, 800 or 1000 *renminbi* (rmb) per night (approximately 78, 125, and 156 US

¹³⁴ Dr. Jing Li. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 7th, 2015.

dollars, respectively¹³⁵) compared to 100-200 (16-30 US dollars) for the common patient rooms. In terms of socioeconomic status, most patients were of middle or upper-class from Shanghai.¹³⁶

According to Dr. Li, most of the women who request cesarean deliveries are those who have more education—university level and up. She told me “when a woman’s educational level is high, they take into account more things. They are afraid, what if the baby turns out bad, or if I am in extreme pain? What if I still have to get the cesarean?”¹³⁷ Similarly, Dr. Chen, the 67-year-old OB/GYN in charge of the patients on the VIP ward, saw similar patterns in those who requested cesareans. They were typically wealthier, “*du sheng zi nu*”, or only daughters that were born after the 1979 one-child policy, and raised in a city. Those who could “*chiku*,” (literally “eat bitter” but translated as “bear hardships”) from having suffered through the Cultural Revolution or from being poor could tolerate the pain of labor. Those who were pampered and spoiled could not, and were therefore more likely to rely on technology. Moreover, she believed that being only daughters, the “*du sheng zi nu*” have been raised to be able to demand what they wanted.¹³⁸

Dr. Chen told me that most women who request cesareans will listen to the doctor’s recommendations and ultimately deliver vaginally; however there are a few, such as some of these “*du sheng zi nu*,” who will continue to demand a cesarean. She told me about Fenfang, a 25-year-old who was admitted to the hospital 39 weeks pregnant, but had not yet started having contractions. She was staying in the VIP ward, paying 800 rmb per night, and requested a cesarean. No matter how much Dr. Chen warned her about the risks, or gave her other medical options like induction of labor, this woman did not sway. She just stayed there, Dr. Chen said,

¹³⁵ “Currency Converter.”

¹³⁶ I administered a brief survey at the hospital and found that, for reference, the average monthly income of a woman with junior high or high school education is 4000-6000 rmb (600 – 900 USD), and of a woman with university and higher-level education is 10,000-15,000 rmb (1500 – 2300 USD).

¹³⁷ Dr. Jing Li. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 7th, 2015.

¹³⁸ Dr. Mei Chen. Informal interview by Eileen Wang. Shanghai, China. July 31st, 2015.

“like a hen sitting on her egg, waiting for it to hatch.” Because Dr. Chen felt like Fenfang and her family were already spending so much money in the VIP room, she acceded to this woman’s obstinacy. She told me repeatedly “from an obstetrics’ point of view” there was absolutely no medical indication, but because she saw no other way of proceeding, she did the cesarean.¹³⁹ I did not see this interaction between this woman and Dr. Chen, so I could not ascertain whether Dr. Chen simply informed her of the facts, or if she had an in-depth conversation about why Fenfang wanted a cesarean (thus digging deeper into the core reasons for her request). I tried to approach Fenfang and her family, to get their perspective, but they declined to be interviewed.

Although I did not get the opportunity to speak with Fenfang, it is noteworthy that she was able to navigate strong state and medical regulations by checking into the hospital of her own accord, and more importantly, using money to stake her demand. She saw the cesarean section and childbirth more as a service to be purchased at the hospital rather than something that was necessarily controlled by the doctor. This phenomenon, as Jingqing Yang suggests, is catalyzed by the commercialization that has been transforming the Chinese health-care system since the 1980s. The shift towards liberalism in the economy of health care, in which public health facilities provide medical procedures and drugs according to market principles, has weakened doctors’ power over patients, as patients’ awareness of their own interests and purchasing power have increased.¹⁴⁰ Furthermore because the hospital continues to generate more user fees from performing more surgeries, providers face, as one nurse-midwife puts it, a “*mao dun*”—a contradiction. On one hand, every surgery, including those requested, brings in more money; on the other hand, the hospital faces pressure to lower the overall cesarean section

¹³⁹ Dr. Mei Chen. Informal interview by Eileen Wang. Shanghai, China. July 31st, 2015.

¹⁴⁰ Yang, “The Power Relationships between Doctors, Patients and the Party-State under the Impact of Red Packets in the Chinese Health-Care System,” 73.

rate to help them retain larger government subsidies. Therefore, in general, while physicians will deny unnecessary cesareans, they are willing to fulfill a request for individual cases like Fenfang. For Fenfang, her purchasing power and stake as a consumer thus acted to soften Dr. Chen's authority and lend her more power in how she wanted to deliver.

Lixue: The valuable test tube baby

In that same record-book of cesarean deliveries, I noted that under the indication column the nurses had also written "test tube baby"¹⁴¹ for some entries. In fact, the indication "test tube baby" was not uncommon; out of the 793 cesarean deliveries from August 1, 2014 to May 31, 2015 at the hospital, 21 were done because the baby was conceived by in vitro fertilization (IVF).¹⁴² But how did IVF provide legitimate justification for a cesarean delivery, given that the method of conception had no direct bearing on the risk of vaginal delivery to the baby's health?

An interaction between Lixue, a woman whom had undergone IVF, and Dr. Chen, her prenatal obstetrician, revealed some insight into those questions. After Dr. Chen had measured Lixue's belly and listened to the baby's heartbeat, Lixue sat down with Dr. Chen to specifically ask her whether she should undergo a cesarean or vaginal delivery. Dr. Chen replied, "A lot of IVF mothers are delivering by themselves now. If you want to try it, you should." She paused. "We can't guarantee a successful vaginal delivery. But you can try."¹⁴³

Dr. Chen actively gave Lixue the choice to have a vaginal or cesarean delivery – a choice that she would not have given to anyone else. When I asked Dr. Chen why women who have conceived by IVF could opt for cesarean deliveries, she responded that generally, the women

¹⁴¹ The literal Chinese to English translation for babies conceived by in vitro fertilization is "test tube baby."

¹⁴² IVF is a medical process by which the egg is fertilized by the sperm outside of the body and its resulting embryo is implanted into the woman's uterus. IVF is usually used for couples who are infertile or cannot conceive naturally.

¹⁴³ Dr. Mei Chen. Informal interview by Eileen Wang. Shanghai, China. July 31st, 2015.

who have IVF babies are older, and age makes vaginal delivery riskier. Furthermore, IVF was more likely to produce multiparous pregnancies, which is also considered a medically acceptable indication for a cesarean.

However, in the case of Lixue, who was 28-years-old and pregnant with only one child, Dr. Chen instead directed my attention to how long Lixue had been married (five years), the number of times she had been pregnant (two), and the number of times she had undergone IVF (once). She then emphasized that each round of IVF is 100,000 rmb (around 15,000 US dollars¹⁴⁴), and that because the parents have invested so much money into the reproduction process, they consider the baby “precious.” If the baby is small and the mother wanted to deliver vaginally, doctors would encourage her to do so, but if the parents wanted a cesarean, doctors would see no problem in doing it.¹⁴⁵

Dr. Chen’s response revealed two insights into cesarean decision-making. First, even in light of the new policies regulating cesarean deliveries, an “indication” for one does not necessarily have to be based in medical or scientific fact. After all, Lixue’s child was not medically different in the womb than any other child. Instead, both the physician and family prescribed a social and economic value to the child because of the expensive process by which it was conceived. As such, I saw, like in the case of Fenfang, those with more money and who invest more into the childbirth process had more leverage in their choice of delivery method. Second, both mothers and physicians continue to believe that cesarean sections are a safer, and more controlled method of delivery for the baby.¹⁴⁶ Dr. Chen’s response alluded to the notion that whereas “success” of a vaginal delivery is not 100%, it is most surely guaranteed for a

¹⁴⁴ “Currency Converter.”

¹⁴⁵ Dr. Mei Chen. Informal interview by Eileen Wang. Shanghai, China. July 31st, 2015.

¹⁴⁶ See Chapter Two on the medicalization of birth.

cesarean delivery, presuming prenatal check-ups are normal. Therefore, like Fenfang, Lixue was able to choose surgery to tame the risky labor process as a consumer of medicalized reproduction and childbirth.

Lanying: Shared medical explanatory models and calculated risk-benefit analysis

Closely associated with the possession of economic capital, women who possessed the intellectual capital to leverage shared explanatory models of childbirth were also able to receive a cesarean from the physician. According to Arthur Kleinman, a psychiatrist and medical anthropologist, an explanatory model is used to explain the etiology, onset of symptoms, pathophysiology, course of sickness and treatment for a particular sickness episode. As he notes, explanatory models “are tied to specific systems of knowledge and values centered in the different social sectors of the health care system.”¹⁴⁷ In the case of childbirth, both women and doctors conformed to the medical model highlighting the risk of vaginal birth and promoting its active management. Some women thus used their own medical knowledge and the language of this shared explanatory model to make the case for a cesarean.

For example, Lanying, whom I introduced previously in Chapter Two, was a college-educated 26-year-old from Shanghai who requested her C-section. I interviewed her in her private room on the 7th floor VIP ward, separate from the common patient wards. Her room had two hospital beds, one for her and one for her family members, two sofa couches, a flat screen TV, its own bathroom and table. It opened out onto the hospital courtyard, with a balcony. Moreover, unlike the women in the common wards who all wore pinstriped hospital pajamas,

¹⁴⁷ Kleinman, “Concepts and a Model for the Comparison of Medical Systems as Cultural Systems,” 88–89.

Lanying was dressed comfortably in a large Paul Frank T-shirt and flowery pajama pants, both loosely covering her fleshy body.

Lanying was soft-spoken, so when I asked her about her birth experience, and why she decided to have a cesarean, it was her husband Jing who responded. Despite Dr. Chen's suggestions that she "could at least try" for vaginal delivery, they felt that her body was too big and that it was too risky to attempt the trial of labor only to have the baby stuck in the womb and then have to get a cesarean anyway.

Jing: When choosing vaginal or cesarean delivery you have to consider each personal circumstance. Typically if you're skinny, it's easier to choose a vaginal delivery. If you're fat, the labor might be long and you might not even have the energy to give birth at the end. It depends on the person. In fact, if she tried to deliver vaginally, 90% and up of people in her circumstance would have to end up getting a cesarean. It's all just a matter of probability.

Me: Who told you that around 90% would have to get a cesarean?

Jing: No, it's something we felt. Because you have to look at the circumstances. In our friend circles and on the discussion boards, we all know. The doctor understands. You can't do anything about it—weight is a factor here.¹⁴⁸

Jing and Lanying had a certain knowledge base—they talked with friends and used pregnancy discussion boards, and they were keenly aware of the risk factors associated with vaginal delivery for a woman of her weight. Even when Dr. Chen suggested Lanying should at least try for a vaginal birth, they used their notion of risk to build a case for prophylactic surgery. Their ability to research as well as articulate their reasoning to the physician enabled them to convince Dr. Chen that it was an appropriate procedure. As Dr. Chen told me, although it was not a clear-cut "medical" indication for a cesarean delivery, being overweight or obese was indeed a risk factor for whether one was able to deliver vaginally without resorting to an emergency C-section. Given that risk was an issue prominent birth decision-making, and they

¹⁴⁸ Jing Huang. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 15th, 2015.

shared the belief that cesareans could manage that risk, Dr. Chen thought it reasonable to accede to Lanying's request.

Nurse-midwife Fang: Dichotomizing provider and mother decision-making

Similarly, Fang Liu, a young and peppy nurse-midwife I often followed around, had given birth to her child nine months ago, and had requested a cesarean delivery without a medical indication. Like Lanying, Fang made her decision predicated on risk. She thought her baby was too big, according to the ultrasound (around four kilograms or 8.8 pounds); that her pelvis was too small; and that she would not have the vigor to deliver herself. Moreover, after having delivered babies as a nurse-midwife for four years, she felt like the process of labor would be too painful. From her medical education, Fang knew that cesarean deliveries were not good, in absolute terms of health, but felt like it should be an individualized decision that took into account her own personality and ability to withstand labor:

If you were to ask me which is better, cesarean or vaginal, I would definitely tell you, vaginal delivery is better. This is definite. Using what we have learned in our specialty training, we have learned vaginal delivery is better because there's less harm to the body, the recovery is faster, all that. But, if you told me to choose, I would still choose cesarean. It's because I felt like I was just too afraid of childbirth pain. I felt like I was afraid of pain. I didn't feel like I was the courageous type of person.¹⁴⁹

Like many other Chinese women, Fang shared a fear of pain and childbirth and was, as a medical professional, perhaps even more socialized to the medical model of birth and conceptions of risk. Indeed, previous studies surveying female OB/GYNs found that about half of females either would have liked to have a cesarean delivery or had already undergone one without medical indication. The reasons they gave were similar to those of other women who

¹⁴⁹ Fang Liu (nurse-midwife). Interview by Eileen Wang. Tape Recording. Shanghai, China. July 6th, 2015.

requested cesareans: fetal and maternal safety, worry about the unpredictability of vaginal delivery, and easier and quicker labor.¹⁵⁰

Women who approached doctors about getting a cesarean for similar reasons, however, would usually receive some sort of response discouraging them from the surgery. In most cases, they would listen or yield to medical authority. On the other hand, Fang was able to request a cesarean without any pushback. She told me, “[The doctor] didn’t tell me to try to deliver myself at all. She just said, ‘Okay, no problem.’” Fang laughed. “It’s because she’s a colleague, right?”¹⁵¹ Because Fang was a part of the medical profession and because she had pre-existing connections with the physicians, she was able to receive the service she asked for.

Still, in her daily work as a nurse-midwife, Fang would often discourage other women from cesarean deliveries, demonstrating the dual role female providers assume in birth decision-making, both for themselves as mothers, and for other women, as medical professionals. In particular, Fang clearly distinguished herself from other women who requested cesareans. When I asked her why women in general would request cesareans, she told me, “I think that they aren’t really clear about what a cesarean is...They think that after surgery it’s not bad, surgery’s nothing. They think vaginal delivery’s risks are higher because they might only have a vague idea of what cesareans are. In reality the risks of surgery are also high.”¹⁵² On one hand, she knew she had the extensive, scientific childbirth education as a medical professional to fully accept the consequences of a cesarean; on the other hand, she assumed that the other women, particularly those of low socioeconomic status, did not fully understand this risk-benefit calculation. This dual mentality justified the apparent contradiction of why providers took a

¹⁵⁰ Zhu, Zhou, and Hua, “Study on the Situation of Cesarean Section in Shanghai”; Ouyang and Zhang, “A Study on Personal Mode of Delivery among Chinese Obstetrician-Gynecologists, Midwives and Nurses.”

¹⁵¹ Ibid.

¹⁵² Fang Liu (nurse-midwife). Interview by Eileen Wang. Tape Recording. Shanghai, China. July 6th, 2015.

paternalistic approach in denying cesareans for some women, but not for themselves or those who could articulate the risk-benefit calculation, like Lanying. At the same time, it reveals how the calculus of decision-making depends on the role that one takes—whether as a provider who takes into account state and professional guidelines in medical-decision making, or as a woman who is giving birth herself.

Pain, class and timing: Legitimacy of the maternal “request”

These aforementioned women all were able to control their childbirth process in the face of prevailing state and medical authority by requesting and receiving cesareans. Indeed, their stories align with current public health literature that note those who have CDMRs are more likely to be educated and of higher socioeconomic status.¹⁵³ Dr. Zhang, for example, told me that women who request cesareans to control their pain are of higher socioeconomic status. By contrast, she told me, “Typically those who come from rural areas, like from other provinces, with lower socioeconomic status—they can withstand the pain. They might yell about it and such but they won’t want a cesarean.”¹⁵⁴

However, I found Dr. Zhang’s response to be problematic. First, she believed that women’s response to pain was a matter of individual constitution and upbringing, echoing similar lines of reasoning rationing anesthesia in childbirth in 19th century United States. As historian Martin Pernick writes, doctors believed that the poor were hardened to pain; while “civilized” women suffered excessively from pregnancy and childbirth, those less civilized were inured to it. As such, doctors emphasized the “civilized woman’s” extra need for pain relief

¹⁵³ Zhang et al., “Cesarean Delivery on Maternal Request in Southeast China.”

¹⁵⁴ Dr. Ye Zhang. Interview by Eileen Wang. Tape Recording. Shanghai, China. July 6th, 2015.

while those of lower orders supposedly needed less protection from pain.¹⁵⁵ This made Dr. Zhang believe it was unlikely that the poor would request a cesarean as a form of pain relief.

But at Jiangbei, I noted that women of all socioeconomic statuses experienced pain and suffering during childbirth, and many women who requested cesareans from pain were, in fact, from rural areas with lower socioeconomic status. Daiyu was from rural Anhui, and had a junior high school education. Huifen, likewise, was from Henan and did not go to college. So why did physicians view the requests of women like Fang as legitimate, while discounting those of women like Daiyu and Huifen?

Timing of the “request”

Perhaps what Dr. Zhang meant was that higher socioeconomic status women typically requested cesareans *before* labor which made them seem more legitimate. Women like Daiyu and Huifen, going into labor, typically preferred a vaginal birth knowing it was better than cesarean delivery in terms of recovery. More importantly, even if they possessed underlying fears of pain or of childbirth that made them want a cesarean, they were more likely to acquiesce to doctor’s recommendations prior to labor.¹⁵⁶ Still, while Daiyu and Huifen did not necessarily articulate they wanted a cesarean section *before* labor, their requests *during* labor were nevertheless calls for the physician to respond.

However, within the labor and delivery room, they continued to be subject to medical authority and paternalistic care. As nurse-midwife Xiulan (who herself pre-emptively requested a C-section because she feared the risk of labor) said in reference to women like Daiyu and Huifen: “They all want to deliver themselves. But once it starts hurting, then they can’t handle it

¹⁵⁵ Pernick, *A Calculus of Suffering: Pain, Professionalism, and Anesthesia in Nineteenth-Century*, 152–153.

¹⁵⁶ Lazarus, “What Do Women Want?”

anymore. So then they'll yell, 'I want a cesarean.' But in fact they don't really want a cesarean. She chuckled. "This kind of pain is one of those pains that you really cannot tolerate. So they feel like if they get surgery they can liberate themselves from the pain."¹⁵⁷ Here Xiulan claimed they do not "really want" a cesarean because requests during labor are made for psychological and emotional reasons, and do not lead to rational, "scientific" decisions for cesarean sections. In the eyes of the physician, all requests relating to the lack of confidence in one's ability to give birth or to labor pain are not scientifically valid—a view reinforced by state policy. As such she did not hear these women's cries for a cesarean as legitimate requests.

"Scientific" versus "legitimate"

However, this distinction between what is or is not a valid request based on "scientific" reasons is problematic. The reasons women request cesareans before labor *are the same* as those who request it during labor, except the former is in response to the *fear of* pain and labor whereas the latter is in response to the *experience of* it. Nurse-midwife Fang, for example, requested a cesarean in part because she feared labor pain. Her reasoning for a cesarean delivery, like Fenfang's or Lixue's, was not any more "scientific"; however, because of her social, economic and intellectual capital, doctors heard her request as a "legitimate" one, and she was able to successfully negotiate it.

Moreover that physicians do not see Daiyu's and Huifen's requests as valid thus effectively renders their appeals invisible. It dismisses the legitimacy of their claim to agency and control over childbirth. When it comes to the experience of labor pain, physicians take a paternalistic stance to these women, assuming that they do not really know what they "really

¹⁵⁷ Xiulan Zhao (nurse-midwife). Interview by Eileen Wang. Tape Recording. Shanghai, China. July 15th, 2015.

want,” as they are not requesting cesareans based on rational risk-benefit analysis. This disparity of power in the doctor-patient relationship is further widened by social class. Negotiations over cesarean deliveries, and who is successful in negotiating them, depend on, as Ellen Lazarus writes, the “interdependence between knowledge, one’s ability to act on such knowledge, the social institutions that constrain actions, and one’s position in the larger structure of society.”¹⁵⁸ As a result, those who actually receive elective cesareans in the context of the new policy are those from the VIP wards—not those of lower socioeconomic status. This view, perpetuated by scholars examining the phenomenon of CDMR using the existing criteria (particularly “before the onset of labor”) brushes over the lived experiences of all Chinese women, as well as the underlying doctor-patient power dynamics that construct the “legitimate request.”

In this chapter, I have described how state and medical authority in childbirth manifests at the point of decision-making, particularly given the recent regulations on CDMR. However, individual accounts of childbirth experiences and negotiations over the procedure reveal women’s agency in this power dynamic. Challenges to this authority, based along socioeconomic lines, demonstrate the underlying ambiguities of medical knowledge and risk that govern the performance of cesarean sections. They also show how economic and social values can determine what constitutes a “legitimate” request even as it deviates from “scientific” medical decision-making. In my conclusion to this thesis, I will reflect on the implications of these power dynamics in cesarean delivery decision-making, and how they inform the experience of childbirth and obstetric care both for women in China and in other contexts. I will also suggest how this research could improve women’s experiences of childbirth in China.

¹⁵⁸ Lazarus, “What Do Women Want?,” 30.

Conclusion

I came to China interested in investigating the context behind a number: the high cesarean section rate. I came away with stories, moments of witnessing the births of new life, and a deeper understanding of the lived experience of reproduction and childbirth in China. Over the course of this experience, I have contemplated what it means to have “control” over childbirth. What I have learned is that there is no black or white answer of what constitutes a “good” birth, or the “best” method of delivery. For the state, birth represents population quality and the future of the nation; for the physician, it means earning a living, managing risk and avoiding medical disputes; for the mother and family, it means ensuring a healthy baby and avoiding pain. The decision to have a vaginal or cesarean birth reflects the intersection of these actors with various goals and agendas.

While many studies have tried to examine the phenomenon of CDMR, I believe that they brush over the lived experience of these women who request, are granted, or are denied cesareans—which I have tried to remedy with this work. Whether one champions a woman’s autonomy and agency in choosing to have a cesarean, or applauds the recent changes in policy restricting unnecessary cesarean sections in China, one must understand how the underlying environment shapes this context of choice and control. As other scholars who have written about elective C-sections have noted, women’s “autonomous” decisions must be contextualized in a system in which the experience of birth is controlled by the medical profession. While the medicalization of birth has saved many mothers’ and children’s lives, it has also led women to look to technological interventions, rather than to social or non-medical forms of support, to

manage their labor.¹⁵⁹ The demand for C-sections thus reflects a deeper issue with the entrenched role of biomedicine governing birth.

As a result, I believe that the overarching question of this thesis is not whether women should “choose” their delivery method but what could best promote their inclusion in a safe and positive birth process, particularly in ways that biomedical practices cannot address.¹⁶⁰ How can we view women not as bodies with states and symptoms but as *people* with lived experiences and fears to make their experience of birth better?

As of now, China has been lacking in these efforts. Rather than taking a “quick-fix” approach to the cesarean section epidemic, it might be better off addressing the lack of pain relief during childbirth, promoting the inclusion of the family in the birth process, and, in the long-term, integrating a midwifery model for low-risk births within its current maternal-services system. Although midwifery was cast as a “backwards” practice in China in the midst of technological modernization and economic development, the midwifery model is not at all “unscientific.”¹⁶¹ It simply operates around a different philosophy—conceptualizing birth as a natural and normal process and valuing less active medical intervention, noninvasive interventions such as social support, and psychological and relational factors.¹⁶² This, in turn, provides psychological benefits to the family and can also reduce unnecessary cesareans from the “ground up” rather than the “top down,” as state policy has tried to do.¹⁶³

¹⁵⁹ Béhague, “Beyond the Simple Economics of Cesarean Section Birthing”; Kuan, ““Suffering Twice.””

¹⁶⁰ Kukla et al., “Finding Autonomy in Birth.”

¹⁶¹ Cheung, “Chinese Midwifery,” 236.

¹⁶² LoCicero, “Explaining Excessive Rates of Cesareans and Other Childbirth Interventions,” 1268.

¹⁶³ Sakala, “Midwifery Care and out-of-Hospital Birth Settings”; Hodnett et al., “Continuous Support for Women during Childbirth”; Rooks, “The Midwifery Model of Care.”

Having held Daiyu's hand during her labor, witnessed Huifen cry in the sterile environment of the delivery room, and listened to nurse-midwives' stories of getting cesarean sections, I felt an overwhelming conviction that these women not only deserved a healthy baby, but also *empathy* and *compassion*—intangibles that the cut of a knife could not provide. Instead of hearing women's requests for cesareans as a call for surgery, I heard them as a call for attention to the social aspects of childbirth and the needs of birthing women, rather than those of the doctors or the state. Changing how we view women and approach childbirth, I believe, can do even more to help and empower these suffering women, whether in China or elsewhere, than biomedicine can do alone.

Appendices

I. A sample brochure available to mothers at the clinic, distributed by Shanghai District Health Promotion Board.



分娩不是自助餐！应该根据孕期母婴的健康状况，在医生的指导下选择科学、适宜的分娩方式。

自然分娩PK剖宫产

●自然分娩对妈妈的益处●

- 自然分娩不经历腹部手术和麻醉的风险，产后腹部无伤口，器官没有受损伤，减少了产后出血和感染的机会

- 产后康复快，既可及早亲自照顾孩子，有利于母乳喂养的成功，又可缩短住院时间节省开支



●自然分娩对宝宝的益处●

自然分娩过程中，胎儿胸部受到产道的挤压，能较好的排出呼吸道中的液体，有利于出生后的呼吸运动的建立，减少新生儿吸入性肺炎和湿肺的发生。此外，胎儿全身皮肤经过产道挤压的刺激，使他接受了人生第一次触觉训练，有利于小儿感知综合的发展。



剖宫产的缺点

●剖宫产的缺点●

- 剖宫产手术对母体的精神和肉体上都是一种创伤

- 手术时有可能发生麻醉意外

- 手术时可能发生大出血，损伤腹内其他器官，术后也可能发生泌尿、心血管、呼吸等系统的合并症

- 术后子宫及全身的恢复都比自然分娩慢

- 剖宫产术后容易发生腹胀、伤口疼痛、腹壁切口愈合不良、血栓性静脉炎等

- 两年内再孕有子宫破裂的危险、避孕失败做人流时容易发生子宫穿孔

- 易发生新生儿窒息、新生儿肺炎等

为方便准妈妈们互相交流，分享孕育经验及心得，特搭建一个QQ互动平台，有兴趣的准妈妈们可以申请加入。QQ群号码：224161276
(准妈妈乐园)



Translation

Natural Parturition: A Healthy Mother's Choice

The Appropriate Mode of Delivery:

A cesarean section is not a free choice of delivery mode. It is a means to solve birth issues and maternal complications, and must be strictly controlled by medical characteristics. If, after assessment and evaluation, it is not feasible to do a safe natural delivery, the doctor will suggest to the mother and her family members to do a cesarean section.

Advice to Healthy Pregnant Women:

Going natural is best. For a healthy mom-to-be, when you choose green foods, appreciate natural sceneries, and pursue natural beauty, why not let your delivery process be more natural and beautiful?

During your pregnancy, if you balance your diet, prepare mentally for natural delivery, learn some natural childbirth knowledge and pain relief techniques, your delivery process will go smoothly and you will be better able to enjoy this short, painful, but happy, period.

Disadvantages of the Cesarean Section:

- Operation can damage mother's physical and mental health.
- Anesthetic complications can occur during surgery.
- Possible surgical bleeding and damage to abdominal organs.
- Postoperative complications may occur in the urinary, cardiovascular, respiratory and other systems.
- The uterus and the body will recover more slowly than with natural childbirth.
- Mother more prone to abdominal bloating, incision pain, abnormal wound healing, thrombotic phlebitis, etc.
- Risk of uterus rupture if pregnant within two years due to contraceptive failure. Abortion operations are also more likely to perforate the uterus.
- More likely to lead to newborn asphyxia, neonatal pneumonia, etc.

Delivery choice is not a buffet! A scientific, appropriate delivery should be based on the health of mother and baby during pregnancy, under the guidance of a doctor.

Benefits of Natural Childbirth to the Mother

- Natural childbirth does not have the risks of abdominal surgery and anesthesia. There are no postpartum abdomen wounds, and organs are not damaged, thus reducing the chance of postpartum hemorrhage and infection.
- Rapid recovery after delivery. One can physically take care of the newborn as soon as possible and is more likely to be successful at breastfeeding. Also shortens the hospital stay and reduces the cost.

Benefits to the Newborn Baby

During the natural birth process, the birth canal squeezes the child's chest, and the liquid in child's airways can be better discharged. This process helps the newborn baby to breathe after birth. Also reduces the risk of neonatal pneumonia. In addition, the baby's skin rubs against the birth canal, enabling it to experience its first tactile motion. This process helps children in their early development in perceiving the new world.

II. A sample brochure available to mothers at the clinic

健康教育处方
JIANKANGJIAOYUCHUFANG



自然分娩的好处



1、自然分娩出血少，对周围脏器影响小。


2、自然分娩后疼痛明显减轻，不需要插导尿管，有利于妈妈尽早下地活动、哺育婴儿，可以更早地进行产后锻炼，对产后体力和体形的恢复有利。

3、自然分娩时，胎儿的头受子宫收缩和产道挤压而充血，可提高脑部呼吸中枢的兴奋性，有利于新生儿娩出后迅速建立正常呼吸。

4、子宫有节奏的收缩会使胎儿胸部受到压迫和扩张，使出生后婴儿的肺泡富有弹性，容易扩张，出生后将很少发生肺透明膜病。

5、胎儿经过阴道时，其胸部受压，娩出后胸腔突然减压而扩大，有利于胎儿出生后自然呼吸。

6、胎儿经过产道时所受到的压力还会刺激胎儿发生应激反应，引起一系列的内分泌改变，尤其是肾上腺皮质激素增多，可促进免疫因子的产生而增强机体的抗病能力；免疫球蛋白在自然分娩过程中可由母体传给胎儿，这也就是为什么自然分娩的新生儿比剖宫产的具有更强的抵抗力。



Translation

Health education prescription:

Benefits of a natural childbirth

1. Natural childbirth produces less bleeding and has minimal effects on the surrounding organs
2. Significant pain reduction after natural childbirth. No catheter insertion. This helps the mother to participate in physical activities, infant feeding, and postnatal exercise more quickly after birth. Also has benefits to the recovery of physical strength and body shape.
3. During natural childbirth, the fetus' head is compressed through the contraction of the uterus and birth canal which can increase the activity of the brain's respiratory center, helping the newborn to rapidly establish normal breathing.
4. Rhythmic contractions of the uterus cause fetal chest compression and expansion, so after the birth, newborn's lung membrane is more flexible and expandable, reducing the risk of developing infant respiratory distress syndrome.
5. When the fetus is pushed through the vagina, its chest is compressed. After delivery, the fetus' chest suddenly expands due to the pressure drop. This process helps the newborn to breathe naturally after birth.
6. The pressure of going through the birth canal will stimulate the newborn's response to sudden change in the outside world, causing a series of endocrine changes in the body, especially an increase in adrenal hormones, which can boost cytokine production and enhance the body's immune system to resist diseases. Immunoglobulin can be transferred from the mother to the fetus in the natural childbirth process, which is why naturally born newborns have better immunity than those born by cesarean section.

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